THE UNIVERSITY OF ALBERTA

# THE PROCESS OF CHANGE:
# THE DEVELOPMENT AND IMPLEMENTATION OF A TEACHING PROGRAM FOR PATIENTS WITH A CHRONIC ILLNESS

by

©

DARLENE JEAN VIGEANT ELLIOTT

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Ms. Darlene Elliott
Doctoral Candidate
Department of Educational Administration
University of Alberta
11436 32 Avenue
Edmonton, Alberta
T6J 3H5

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PERMANENT ADDRESS:

11436 - 32 Avenue
Edmonton, Alberta T6J 3H5

Date: October 9, 1985

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled THE PROCESS OF CHANGE: THE DEVELOPMENT AND IMPLEMENTATION OF A TEACHING PROGRAM FOR PATIENTS WITH A CHRONIC ILLNESS submitted by DARLENE JEAN VIGEANT ELLIOTT in partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY.

Supervisor

R. G. McIntosh

Peggy Anne Field

Gene E. Hall
External Examiner

Date: September 25, 1985

# ABSTRACT

This case study was conducted to describe and explain the process of change on one particular nursing unit. One general research question was asked: What happened when four staff nurses on unit Y in a large Canadian hospital attempted to develop and implement a teaching program for patients with a chronic illness? Seven sub-questions guided the study: Through what stages did the change progress and what was the change process like? What were the characteristics of the change? What strategies of change were utilized? What factors facilitated or inhibited the process of change? What were the characteristics and influence of individual roles on the change? What was the influence of antecedent conditions on the change? What were the outcomes of the change?

Between September 1982 and September 1984, combining theory from the literature on the change process with an analytical design based on program evaluation and using a variety of sampling plans, the investigator collected data from 28 informants who had become involved in the change process. The data from 60 interviews, documents on the unit which covered a three year period, and field notes generated by the investigator over the two year period were analyzed using qualitative techniques.

The findings confirmed: (1) that change is a process not an event, (2) that the change process progresses through stages in a contorted way, (3) that the stages of the process are interrelated, and (4) that the change process is influenced by numerous interrelated factors. The fourteen factors that influenced the change process in this study were:

1. Need for the change
2. Leadership
3. Support of others
4. Resources
5. Antecedent conditions
6. Clarity
7. Complexity
8. Multiple realities
9. Staff development
10. Planning for each stage
11. Knowledge of and experience with the process of the stage
12. Materials production
13. Information systems
14. Domain of the discipline

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I would like to also express my appreciation to the nurses, doctors, and patients who cooperated with and so candidly confided in the investigator to make this study possible.

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# CHAPTER 1

# OVERVIEW OF THE STUDY

## Introduction

In April of 1982, a medical unit specializing in the care of patients with a chronic illness, opened in a large Canadian hospital (hereinafter referred to as hospital X). The unit (hereinafter referred to as unit Y) was to be the setting for the development of a planned change strategy.

In August of 1982 the head nurse prepared a proposal to request approval and funding to operationalize one of the mandates of the unit; that being to develop and implement a teaching program for chronically ill patients on unit Y. The head nurse invited the investigator to visit unit Y and to discuss the feasibility of conducting a study about the change process while the program was developed and implemented.

During December of 1982 and January of 1983, the unit received approval and external funding to support the program. This study was then begun.

## Purpose of the Study

The purpose of the study was to conduct an inquiry about the process of change, specifically to describe and analyze the development and implementation of a teaching program on unit Y. The following question for inquiry was posed: What happened during the development and implementation of a teaching program for patients with a chronic illness?

## Need for the Study

The need for this research on the process of change in the health care setting was justified on several grounds. First, the hospital unit under study requested this kind of study be undertaken. A second justification, often cited in interdisciplinary literature on change, was that programs or policies were often initiated or adopted, but, upon close examination were found not to have been implemented by the intended users (Fullan, 1982). A third justification cited in the literature was that, although the effectiveness of the change was often evaluated, the 'event in action' was rarely studied to provide clues as to why or how these outcomes came about (Van De Ven, 1980). A fourth justification was simply that the author was in the right place at the right time. Rarely is the opportunity afforded an investigator to begin research as change is being initiated. Finally, and perhaps most important, an analysis of the literature indicated that limited study of the process of change in health care settings had been conducted.

A literature search revealed a body of published literature in which the title of and/or the content of the material focussed on change in the health care setting. Materials reviewed included recent books (Stevens:1980, Mauksch:1981, and Lancaster:1982), annotated bibliographic manuals (Aydelotte:1973, Young et al.:1980, and Munson:1980), a comprehensive review of research in health care settings (Georgopoulos, 1975), and in excess of 50 articles published in health care journals during the seventies and eighties.

Inherent in the materials reviewed were two fundamental assumptions. The first assumption was that change was an ever present force in health care settings (Spradley, 1980). The second assumption was that change was a process, not an event (Stevens:1980, Mauksch:1981, Lancaster:1982). If these two assumptions were correct, one would expect to find an abundance of findings from the studies which identified the constructs of the domain of change, the characteristics of the constructs, the specific factors which facilitated or inhibited the process of change, and some indication of how and why the factors operated as they did or how 'changing' occurred. Such findings were not evident.

A disappointing state of affairs existed in the literature about the process of change and the so-called studies on planned change in health care settings. Four findings from the literature will be discussed. First, studies of change in health care settings were grounded in the work of the recognized change scholars (Rogers, Chin, Benne, Bennis, Havelock, Lewin, and Lippitt). However, analysis of the reports indicated that no theories of change specific to the health care settings had been generated, that few studies had been carried out to test traditional theory application in health care settings, and that few, if any, factors had been identified which supported or expanded the traditional theory of planned change when such theory was applied to health care settings.

In addition, the literature exhibited a lack of awareness about the important research being done on change in other areas, such as policy analysis and education, during the seventies and eighties. The works of Berman, Elmore, Fullan, Hall, Leithwood, Leiberman, Loucks, Majone, McLaughlin, and Wildavšky appeared in few, if any, reference lists in the nursing literature on the process of change.

Second, although the reports discussed change, the definite focus of the studies was on outcome, not the meaning or the process of change. The study reports were analyzed to determine if one of the constructs of change, stages of change (which were identified in the interdisciplinary literature), could be identified. Also of interest was the ability to determine the stage of change (initiation, implementation, continuation, or outcome) on which the report focussed. Few of the reports had the stage of initiation or implementation as a focus. No report focussed on continuation.

A large number of reports had an assessment of the outcome of the change and not an examination of the process stage as the primary focus of the report. This finding was somewhat disturbing when considered in the light of the interdisciplinary knowledge about the change process. Hall and Loucks (1982) warn that outcome evaluation should not be undertaken until the change is well stabilized or routinized. The assessment of change effectiveness, in the reports, occurred on a time line from one month to four years after initiation of the change, with the majority of assessment taking place early in the process rather than later. Also disturbing was the finding that the reports about the implementation of patient teaching programs, with which the present study was most concerned, focussed on outcomes with little concern for the process.

Third, the studies clustered around the extreme ends of a research design continuum. Either the study exhibited limited methodological adequacy and could be thought of as little more than a retrospective anecdotal report or the study design was excessively quantitative and gave no indication of why a program or change was judged to be effective or how the changing had occurred. The Johnson study (1982) was a case in point.

Johnson (1982) reported on the effects of a patient education course on persons with a chronic disease. The purpose of the study was to measure the effects of a structured patient-centered educational program on a person's ability to cope with chronic illness. Fifty-two out-patients who had been diagnosed as having cancer were randomly selected and measured on three dependent variabies: anxiety, meaningfulness in life, and knowledge about cancer. Pairing of participants according to pre-test scores resulted in random assignment of pairs to a treatment or control group. The treatment group then attended a four week educational program, offered in eight sessions. The control group received no program. The test was again administered upon completion of the program. Multivariate analysis indicated that the patient education course was found to have a significant effect on the patients' scores for each of the three dependent variables.

While the study provided statistical proof that a change occurred in the treatment group, one was not convinced that the program alone accounted for all the variance and was left to question what it was about the program that accounted for the change. Questions like:

What happened to the patients? What was it about the program that influenced the patients scores to change? What happened to the nurses? What side-effects occurred which might be attributed to the program? What was the effect on the patient of just being a part of the program (the Hawthorne effect), especially on two of the variables, anxiety and meaning of life were left unanswered.

While the Johnson study achieved the purpose for which it was conducted, to examine the effectiveness of the program, one was left to speculate why the intended outcome was achieved. Generalizability from such a study was difficult, in spite of the rigorous methodology employed, without the inclusion of such critical process information. Johnson, herself, alluded to the need for this kind of information when she recommended that the program should be implemented with persons from other backgrounds and that the uniqueness of the individual instructor and the characteristics of the specific setting should also be considered. She, however, neglected to recommend that the process of implementing and evaluating the program should also be of prime study interest, in addition to the achievement of intended patient outcomes.

Fourth, only one study was identified which attempted to study the process of change in the health care setting. McGill and Kelly (1983) reported on a research project designed to examine the organizational change process. The project was undertaken to collect information, on which to base administrative action about employee concerns over the merger, under one new facility, of five distinct paediatric care facilities in Vancouver, British Columbia. What began as a project with short-term funding subsequently became a three-and-a-half-year study. The study seemed to address what Fullan (1982) refers to as the 'meaning of change'; for change to be successful, it must be internalized at the level of each individual. The Vancouver project appeared to have progressed through a number of phases.

In phase one, key issues were identified from the literature and formed the basis for a set of open-ended interview questions which were asked of a random stratified sample of 180 (N = 1000+) staff and physicians. The questions asked were (McGill, 1983:28):

1. What do you consider to be the (opportunities) (problems) in moving to the new Children's Hospital?
2. What do you like (most) (least) about your present job?
3. What information would you like to have about the new Children's Hospital?
4. How should new Children's Hospital administration get planning input from your level of staff?
5. Do you have any suggestions for helping people to manage the transition?

In addition, the staff were asked to speculate about aspects of the working environment that would be the same, better, or worse at the new hospital. Content analysis of the data revealed four major themes which could be collapsed to reveal the need for and potential benefit of effective communication. In response to this identified need, Children's Hospital administration appointed a full-time person to act as a communication facilitator.

In phase two of the project, the communication facilitator began her task and continued on to establish ongoing interventions. Such interventions included talking confidentially with staff, facilitating communication between persons and groups, distributing communications literature, encouraging management and staff to communicate changes as soon as possible, and clarifying communication channels. Qualitative data were collected from anecdotal recordings. Quantitative data were collected from a questionnaire on organizational stress.

Preliminary findings indicated that the communication facilitator's interventions were effective and that the organizational stress level was declining. The study is still continuing, but even at this early date illustrates the richness of findings generated when a description and analysis of the development and implementation of a change process in undertaken.

Clearly, more studies about the process of change in health care settings were needed. Based on the above review of the literature about the process of change in health care settings, this investigator recommended that:

1. Methodologically adequate studies be conducted to examine the meaning of and the process of planned change in health care settings rather than, or in addition to, studies of only outcomes or effectiveness of planned change.
2. Studies of planned change 'in the making' (process in action) in addition to retrospective studies be conducted.
3. The advantages of inductive approaches for examining 'meaning in context' be recognized and that such approaches to inquiry be utilized when appropriate.
4. Studies be conducted to examine the process of change over an extended period of time.

The present study was conducted in an attempt to respond to the above recommendations.

## Significance of the Study

While the interdisciplinary areas of organizational effectiveness, policy analysis, education, and agriculture have had a long-standing history of research and recognition of the significance of studies of the change process, the same cannot be said for nursing. As has been demonstrated in the above argument supporting the need for the study, research on the change process in health care settings has been disappointing. There seems to be little doubt that this study should provide useful information to participants in this change, the administration of hospital X, other units in this hospital or other health care agencies which plan to develop and implement a patient teaching program or undertake a planned change. In addition, it was expected that the findings, conclusions, and recommendations of the study should reach beyond the boundaries of the health care setting.

One such area is that of education. Michael Fullan at the Ontario Institute for Studies in Education and Gene Hall at the University of Texas at Austin are presently producing articles and conducting studies on the process of change in educational settings at an impressive rate. Fullan (1985:392) recently put out this request to researchers:

> Studies that trace change over a period of time (even short periods) are essential to inferring how people change. Research needs to go beyond theories of change (what factors explain change) to theories of 'changing' (how change occurs, and how to use this new knowledge).

The present study may, therefore, provide useful information to the broader research community which is interested in theories of change and theories of changing.

## The Domain of the Inquiry

The domain of inquiry in the study was that of change. An initial review of the literature was undertaken to determine what the domain of change looked like, what might be some of the constructs of the domain, and what might be some of the elements, factors, and variables within the constructs. The investigator anticipated that such an inquiry would generate sub-questions to guide the study.

### What the Domain Looked Like

Reference to change appeared in the literature from a variety of study areas: organizational development (Fullan, Miles and Taylor:1978), organizational effectiveness (Mott:1972, Steers:1977, Lawler:1980, Van De Ven:1980), and policy development (Elmore:1978, Pressman and Wildavsky:1973). Although the areas of study were diverse, most writers agreed that change was a process, not an event (Hall and Loucks:1977, Stevens:1980, Blanchard and Zigarmi:1981, Mauksch:1981, Fullan:1982, Lancaster:1982). The process of change was examined most frequently by the writers in terms of stages or phases.

### Stages of the Process

Lewin (1951) identified the three steps in the change process as: unfreezing, moving to a new level, and refreezing. Rogers (1962) described five phases in the change cycle as follows: awareness, interest, evaluation, trial, and adoption.

In 1969, Havelock reviewed the existing literature on change and developed a framework for understanding the processes of innovation, dissemination, and knowledge utilization. He concluded that the principal models of dissemination and utilization could be grouped according to three perspectives: (1) research, development and diffusion, (2) social interaction, and (3) problem solving. He suggested that a "linkage model" could incorporate the best features of all three perspectives. In the linkage model he identified the six stages of planned change: (1) building a relationship, (2) diagnosis, (3) acquiring relevant resources, (4) choosing the solution, (5) gaining acceptance, and (6) stabilizing the innovation and generating self-renewal. Lippitt (1973) suggested there were seven steps in the change process: diagnosis of the problem, assessment of the motivation and capacity for change, assessment of the change agent's motivation and resources, the selection of progressive change objectives, choosing an appropriate role for the change agent, maintenance of the change once it had been started, and termination of a helping relationship. Berman and McLaughlin (1976) viewed the innovative process as consisting of three stages: initiation, implementation, and incorporation.

Fullan (1982, 1985) provided detailed reviews of the recent literature on change in the educational setting and concluded that there were at least three broad phases to the change process: initiation/adoption, implementation, and continuation. In addition, Fullan added the concept of outcome as a fourth stage.

## Factors Which Influence the Change Process

Lists of factors which influenced the process of change have appeared in the literature. R. Hall (1982:207-215) reviewed the research findings about innovation and concluded that organizational characteristics, the values of elites, and environmental pressures all contribute to change and innovation. Hanson (1979:287-359) discussed research findings of innovation studies as they related to the organization, the individual, and the environment.

Organizational characteristics. Hage and Aiken (in R. Hall, 1982:213) found that the following organizational characteristics were related to high levels of innovation: a) high centralization of power, b) low formalization, c) low stratification in the differential distribution of rewards, d) a low emphasis on volume of product, and e) a low emphasis on efficiency in the cost of production of services. According to Corwin (in Hanson, 1979:324), innovation increased with size of the city and size of the school. In the view of Moch and Morse (in R. Hall, 1982:213) innovation was related to: of Moch and Morse (in R. Hall, 1982:213) innovation was related to: a) organizational size, b) specialization, c) differentiation and decentralization, and e) values of the lower-level decision makers.

Blau (in Hanson, 1979:303) reported that innovation was positively related to 'security' of the higher level administrators. Carlson (in Hanson, 1979:305) reported a positive relationship between innovation and amount of mix of the old and new way of doing things. Miles (in Hanson, 1979:306) revealed a negative relationship between innovation and the amount of dollars recently sunk into the system. Watson (in Hanson, 1979:306) found that successful innovation was related to the recognition of a four-stage cycle of resistance.

Individual characteristics. Corwin (in Hanson, 1978:324) found that innovation increased with: a) education level of teachers, b) experience of teachers, c) male teachers, and d) teachers who belong to local and national educational associations. According to Hage and Aiken (in R. Hall, 1982:213) successful innovations were related to: a) high complexity in the professional training of organizational members, b) high concentration of cosmopolitan professionals, d) high consideration for the values of the dominant coalition, and e) a high level of job satisfaction on the part of organizational members. Hage and Dewar (in R. Hall, 1982:214) argued that the values of the elites in organizations were more important than the structural characteristics.

Smith and Keith (in Hanson, 1979:313) reported successful innovation to be related to how teachers responded after the innovation had been implemented. Orlansky and Smith (in Hanson, 1979:324) suggested that successful innovations were those that required a minimum of employee retraining. Rogers and Svenning (in Hanson, 1979:324) noticed that successful innovations were related to: a) individual's perceptions of the situation as a crisis, b) individual's perception of the advantages of the innovation, c) compatibility of the new ideals with individual's previous ideas, values and needs, e) how complex the individuals perceive the innovations to be, f) allowing time for individuals to test the innovation, and g) how easily the essence of the innovation can be communicated to individuals.

Environmental conditions. According to Corwin (in Hanson, 1979:324), innovation increased with: a) support from community and teacher organizations, b) joint programs with the community, and c) federal programs in the schools.

Fullan's factors. Fullan (1982) indentified factors which were associated with each of the stages of initiation, implementation, continuation and outcomes. According to Fullan (1982:42), the factors associated with the initiation/adoption stage were:

1. Existence and quality of innovations.
2. Access to information.
3. Advocacy from central administrators.
4. Teacher pressure/support.
5. Consultants and change agents.
6. Community pressure/support/apathy/opposition.
7. Availability of federal or other funds.
8. New central legislation or policy (federal/state/provincial).
9. Problem-solving incentives for adoption.
10. Bureaucratic incentives for adoption.

The factors which Fullan (1982:96) thought affected implementation were:

A. Characteristics of the Change

   1. Need and relevance of the change.
   2. Clarity.
   3. Complexity.
   4. Quality and practicality of program (materials, etc.).

B. Characteristics at the School District Level

   5. The history of innovative attempts.
   6. The adoption process.
   7. Central administrative support and involvement.
   8. Staff development (in-service) and participation.
   9. Time-line and information system (evaluation).
   10. Board and community characteristics.

C. Characteristics at the School Level

11. The principal.
12. Teacher-teacher relations.
13. Teacher characteristics and orientations.

D. Characteristics External to the Local System

14. Role of government.
15. External assistance.

Fullan (1982:76) reported that successful continuation of a change was related to: a) high level of local interest, b) ability to fund at the local level, c) high level of central office interest and support, d) early, active, and continued attention of district managers, e) decreased external resource support, and f) continuation of key user members. Finally, Fullan (1982:77) identified the five kinds of outcomes of change efforts to be measured as: a) degree of implementation, b) attitude toward innovation, c) impact in terms of students' beliefs and organizational benefits, d) continuation of institutionalization, and e) attitude toward school improvement.

## Studies of Change in Educational Settings

The reports of studies on change which had been conducted in educational settings were of greater magnitude and provided findings, conclusions and recommendations in greater detail than had those studies reported in the nursing literature. Such reports provided additional insights as to what the domain of change was all about and about how one might undertake a study of the scope and magnitude which the present study appeared to require.

In 1971, Smith and Keith published their classic study about an innovation at Kensington Elementary School. The authors remained in the school as observers for the first year of the change. The purpose of their study was to examine what happened when a new and uniquely designed school opened with a mandate to develop pupils toward maturity. Specifically, the researchers set out to analyze: the development of the faculty social system, the principal's role, the teacher's instructional innovations, and the development of the school-wide pupil social system. The innovation was not successfully implemented. Smith and Keith (1971:3) report "Now, two years after it [Kensington School] began, it does not exist as it once did." The innovation was not successfully implemented for a number of reasons. First, the alternative of grandeur rather than incrementalism was chosen for the innovation. A high level of uncertainty resulted and a high number of unintended outcomes occurred throughout the innovation. Second, a temporary system strategy was adopted at Kensington resulting in increased uncertainty. Finally, the chief executive officers of Kensington School gambled on minimal prior commitments of participants; they lost.

Charters and Pellegrin (1972) conducted on site studies for four schools which were implementing an innovation. The following barriers to the innovative process were identified at the end of one year:

1. strain between the ideology of teacher governance and strategy of directed change
2. lack of definition of the change
3. heavy reliance on structural change
4. assumption that a statement of abstract values would translate into new behaviors
5. unrealistic time perspective

6. ambiguity between established administration and project management
7. lack of teacher's experience in collaborative decision-making
8. conflict in goals, values, and interests of participants
9. absence of monitoring procedures to assure implementation
10. failure to recognize role overload
11. constraints of the time schedule, and
12. failure to provide additional resources.

Berman and McLaughlin (1976:347) conducted a study to examine the process of innovation and the factors affecting innovation in schools. They asked four questions.

> How should the nature and extent of innovation and dissemination of new practices in the public schools be assessed?
>
> How do school districts select, introduce, implement, incorporate, and spread different kinds of innovations?
>
> How do differences in the federal programs, in project characteristics, and in local settings affect how projects are begun, carried out, continued on local funds and disseminated?
>
> What should federal policies be toward educational innovation in light of the political, financial, and organizational constraints that the federal government faces in its dealing with the public schools?

The research design developed by Berman and McLaughlin (1976:365) included a literature review, a nation-wide survey of 293 change agent projects, field studies at 29 project sites, and interviews with officials who worked on four of the change agent projects. They concluded that:

a) implementation, rather than the adoption of a technology, the availibility of information about it, or the level of funds committed to it, dominated the innovative process and its outcomes,

b) effective implementation depended on the receptivity of the institutional setting,

c) effective implementation was characterized by the process of mutual adaptation, and

d) local school systems varied in their capacity to deal with innovations and with the stages of the innovative process.

Fullan and Pomfret (1977:367) reviewed 15 studies of curriculum and instruction implementation. Five dimensions of implementation in practice were found: changes in materials, structure, role/behavior, knowledge and understanding, and value internalization. The implementation studies displayed one of two main orientations: fidelity or mutual adaptation. In addition, the factors which were common in implementation were identified and grouped into four broad categories:

A. Characteristics of the Innovation

1. Explicitness (what, who, when how).
2. Complexity.

B. Strategies

1. In-service training.
2. Resource support (time and materials).
3. Feedback mechanisms.
4. Participation.

C. Characteristics of the Adopting Unit

1. Adoption process.
2. Organizational climate.
3. Environmental support.
4. Demographic factors.

D. Characteristics of Macro Sociopolitical Units

1. Design questions.
2. Incentive system.
3. Evaluation.

### 4. Political complexity.

Simms (1978:vi) reported his findings about the implementation of an innovative language arts program in two Alberta elementary schools. The study focussed on the degree to which the schools were actually implementing the program and on the factors which accounted for the degree of implementation. He reported that the most important conclusions were associated with the inadequacies in the implementation strategy. First, the design of the implementation strategy was not based on an analysis of the interrelationships between the attributes of innovation (the program) and the characteristics of its user system (the schools). Second, there was no clear statement of the goals, objectives and priorities of the implementation strategy. Third, there was no clear operational description of the constituent elements of the strategy, together with a statement of the objectives of each. Fourth, there was no viable procedure for the on-going evaluation of the implementation strategy being utilized. Finally, there was a lack of precision in the way the implementation strategy was operationalized.

Miles (1979) studied the planning and implementation of innovations in six public schools. He identified eight key dilemmas as being: a) innovative vs familiar choices, b) goal adherence vs revision, c) environmental contact vs withdrawal, d) expertise-seeking vs self-reliance, e) feedback utilization vs intuitive action, f) implementation constraint vs automony, g) laissez faire vs intervention, and h) routinization vs flexibility. He suggested six primary tasks for dilemma resolution. First, mobilize legitimacy and power for the planning/implementation group. Second, search for and use technically valid information. Third, create a clear map of the future school, well tied to the goals. Fourth, create a clear blueprint of the school's social system. Fifth, operationalize the social blueprint. Finally, stabilize the new school. In addition, Miles identified six key capabilities which the participants as a group possessed. They gained legitimacy as a planning and action group, developed their investment in terms of building motivation and commitment of participants, utilized meta-planning, possessed political skill in obtaining resources, monitored their own actions and based future actions on these results, and finally they produced technically sound decisions.

Levin (1981) reviewed ten cases in which effective implementation occurred. The cases cut across the areas of education, health care, defence, and labor relations in the United States. Nine conditions which seemed conducive to effective implementation were identified as: a) strong leadership, b) favorable contact, c) support of private interest groups, d) newness of an organization, e) autonomous structure, f) coercion, g) technological task nature and problem solution, h) involvement of outsiders of the political constituency, and i) law enforcement task nature.

In 1982, Hall and Loucks provided an updated report of the research on the change process which was conducted at the Research and Development Center for Teacher Education at the University of Texas (Austin). The research enlarged upon the Teacher Concerns Model developed by Fuller in 1969. Hall, Wallace and Dossett (1973) developed the Concerns Based Adaptation Model (CBAM). One dimension of the CBAM identifies seven Stages of Concern about innovations. The seven stages are identified as: awareness, informational, personal, management, consequence, collaboration, and refocusing.

Another dimension of the CBAM, addresses the use or nonuse behaviors of persons in relation to an innovation. This dimension, Levels of Use of an Innovation (LOU), consists of eight dimensions: nonuse, orientation, preparation, mechanical use, routine, refinement, integration, and renewal. They concluded that a summative assessment of implementation of an innovation should be focussed on level IV(a)-routine use. Inherent in the work of Hall and his colleagues was something which Fullan (1982) referred to as 'the meaning of the change'.

## The Meaning of Change

History has provided evidence that while many innovations are planned and adopted, few succeed to long term continuation. Consequently, two questions arise. How many innovations are really implemented? Why does there continue to be a failure of implementation and continuation of adopted projects? Fullan attempted to provide some insight about the problem.

Fullan (1982:ix) identified two questions to be asked when one examines a situation in which change is involved. What has actually changed in practice? How do we know when change is worthwhile? The answer to the two questions lies in resolving the problem of meaning in change, which according to Fullan involved finding meaning about what should change as well as how to go about changing.

Lieberman (1978, 1982), Dawson (1978), Leithwood (1981, 1981a), and Fullan (1982) are among a number of current researchers who are 'returning to the drawing board' to examine the meaning of change from an individual perspective. Fullan (1982:24-26) provided evidence that change was a serious personal and collective experience, involved individual loss, and was characterized by ambivalence and uncertainty. He suggested that the anxieties of uncertainty and the joys of mastery at the individual level were central to the meaning of change, and to the success or failure of change. According to Fullan (1982:26), a better understanding of the nature of these anxieties and joys could be gained by examining the subjective and objective meaning of change.

Fullan discussed the subjective meaning of educational change by examining the existing reality of the teacher's world. On the surface these realities appear similar to those of the nurse. Fullan (1982) suggested that these realities were powerful constraints to change. The teacher's world was multidimensional, simultaneous, and unpredictable. In addition, the teacher's world exhibited fixity, little room for change, and a strong tendency to change as little as possible. Fullan supported Sarason's (1971) conclusion that under these kinds of conditions, rational change might be ineffective if it ignored the culture of the organization.

The objective reality of educational change according to Fullan (1982:30) was multidimensional. He identified three of the dimensions to be concerned about as: new materials, new teaching approaches, and an alteration of beliefs. These dimensions seemed appropriate for examination in the world of the nurses in this study. Fullan went on to identify three difficulties associated with dealing with the three dimensions. The difficulties involved who developed the materials and defined the approaches and decided on the beliefs?, which of two approaches would prevail (fidelity or evolutionary)?, and what were the objective dimensions of the change? Fullan (1982:33) provided some enlightenment for dealing with difficulties about the objective reality of change by presenting three lessons to be learned when thinking about change. Change is multidimensional. Change involves deep changes. Change consists of a dynamic interrelationship of the three dimensions.

In addition to alerting one to the lessons that must be learned about the subjective and objective meaning of change, Fullan (1982:36) examined the implications of those realities. He suggested that those involved with change make seven major observations. These observations should be concerned with: the soundness of the proposed change, an understanding of the failure of well intentioned change, the guidelines for understanding the nature and feasibility of particular changes, the implications for planning, the realities of the status quo, the deepness of the change, and the question of valuing. Fullan (1982:38) emphasized the importance of individual understanding to the meaning of change:

> The presence or absence of mechanisms to address the ongoing problem of meaning--at the beginning and as people try out

ideas--is crucial for success, because it is at the individual level that change does or does not occur.

## Sub-questions to Guide the Inquiry

Based on the preceding ideas which emerged about the domain of planned change, a simplistic overview of the constructs and the elements of the domain of planned change was developed and appears in Figure 1.1. Using the simplistic overview as a guide, seven general sub-questions were developed to guide the inquiry about: What happened during the development and implementaton of a teaching program for patients with a chronic illness? The seven sub-questions were:

1. Through what stages did the change progress and what was the change process like?
2. What were the characteristics of the change?
3. What strategies of change were utilized?
4. What factors facilitated or inhibited the process of change?
5. What were the characteristics and influence of individual roles on the change?
6. What was the influence of antecedent conditions on the change?
7. What were the outcomes of the change?

Other questions were generated as the research proceeded. Bogdan and Biklen (1982:55) had predicted: "Finding the questions should be one of the products of data collection rather than assumed a priori."

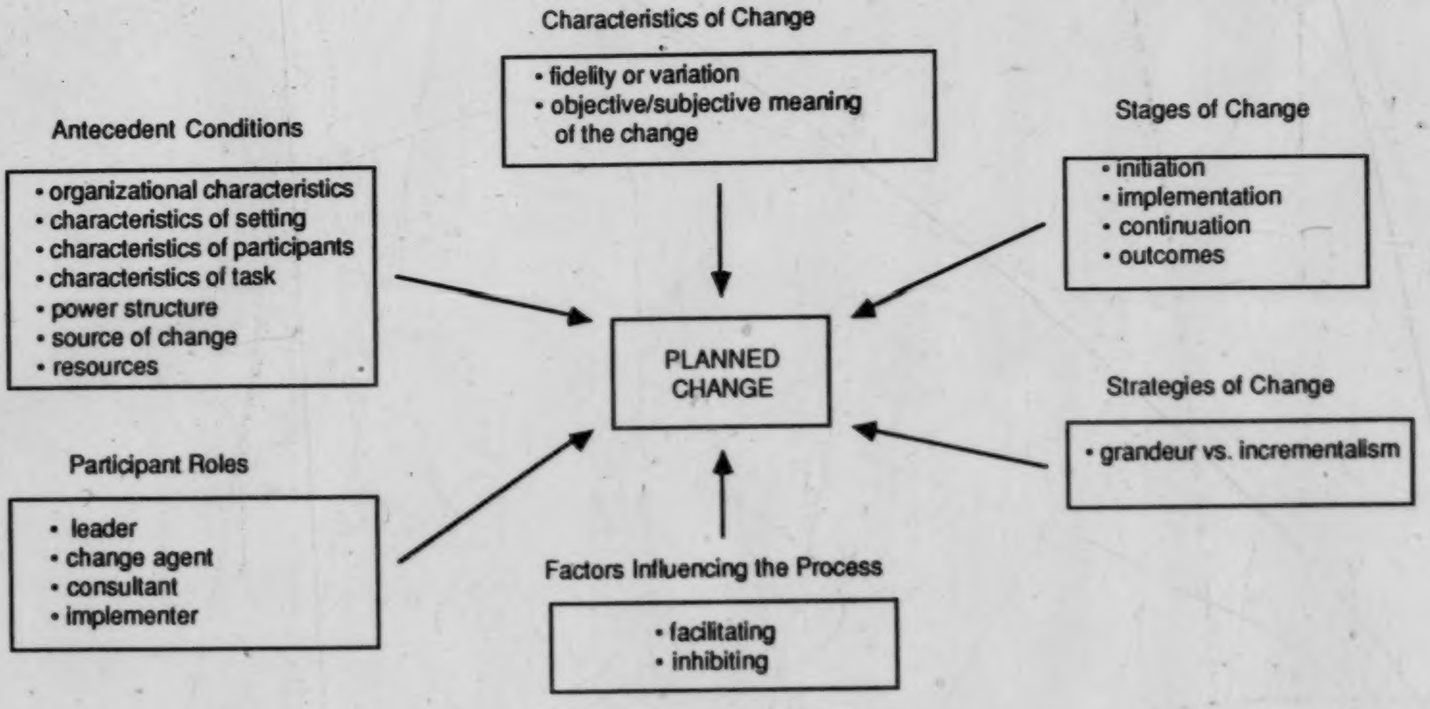

Characteristics of Change
• fidelity or variation
• objective/subjective meaning of the change
Antecedent Conditions
• organizational characteristics
• characteristics of setting
• characteristics of participants
• characteristics of task
• power structure
• source of change
• resources
Stages of Change
• initiation
• implementation
• continuation
• outcomes
PLANNED CHANGE
Strategies of Change
• grandeur vs. incrementalism
Participant Roles
• leader
• change agent
• consultant
• implementer
Factors Influencing the Process
• facilitating
• inhibiting

**Figure 1.1**

Constructual Elements of the Domain of Planned Change

## Limitations of the Study

1. The study was time bound by the period between August 1982 and September 1984.
2. The study was limited to the responses collected during the interviews, observations made on the unit, and the information available in collected documents during the study period.
3. The study was limited to the acute care hospital setting.
4. The study was limited to patients with a chronic illness who were treated within the acute care hospital setting.
5. The findings, conclusions, and recommendations are posited only as they relate to the present study.

## Definition of Terms

A number of terms and phrases frequently used throughout the report require clarification. The position titles of persons contained in the document were developed for reporting purposes (e.g., head nurse, area supervisor). Other terms were developmental, their meaning evolving or changing as the study progressed (e.g., class, session, program). As a rule the meaning which the informants attached to a given term is clear in the context of the evidence which is presented. The investigator attempted to use the same terminology as the informants throughout the document.

| | |
|---|---|
| The Association: | refers to a volunteer organization, made up of people who have the chronic illness. The |

| | |
|---|---|
| | Association provided external funding for the program. |
| Area supervisor: | refers to a nurse who reports to a director of nursing service and is resposible for the overall supervision of four of five units. In this study the nurses considered this position to be part of senior nursing administration. |
| Charge nurse: | refers to a senior staff nurse on a unit who takes the place of the head nurse, in her absence, and supervises the unit. |
| Chief Executive Nursing Officer (CENO): | refers to the highest level nursing position in the organization. This position usually reports to the chief executive officer of the organization. The director of nursing service reports to this position. This position is considered to be part of senior nursing administration. |
| Chronic illness: | a non life-threatening debilitating condition affecting males and females who are usually in the young adult to older age group. |
| The class: | also referred to by the informants as the 'lecture' or 'session' which the teaching nurses taught to the patients. |
| Departments: | refers to specialized organizational units within the hospital (e.g., department of physiotherapy, dietary department, pharmacy department, x-ray department, finance department, department of nursing). |
| Director of nursing service: | refers to one of two or more nurses who report to the chief executive nursing officer and to whom a dozen or so area supervisors report. This position is responsible for the overall functioning of one large area of nursing service under the umbrella of the department of nursing (e.g., medical or surgical or rehabilitation). This position is considered to be part of senior nursing administration. |
| Full-time: | refers to being hired for a regular complete complement of work within a given time period, usually two weeks. |

| | |
|---|---|
| Head nurse: | refers to the position responsible for the nursing care on and the operation of a given nursing unit. In this study three nurses at different times assumed the position of head nurse. Upon leaving the unit, the first head nurse was referred to as the former head nurse. The head nurse position was filled temporarily by a staff nurse who was referred to as the 'acting head nurse' until she was permanently appointed to the position, at which time she became the 'new head nurse' or the 'second head nurse'. The 'new head nurse' upon assuming the position of permanent head nurse immediately took a leave of absence. The position of head nurse at that time was filled temporarily by a third nurse who was referred to as the 'second acting head nurse'. |
| Nursing administration: | refers to the positions of chief executive nursing officer, director of nursing service, and area supervisor. In this report the term was used interchangeably with the term 'senior nursing administration'. |
| The old program: | refers to a teaching program for patients with a chronic illness which was designed by one physiotherapist in hospital X and was delivered prior to April 1982 by the physiotherapy department. |
| 'On take': | refers to the practice of leaving three to five beds open on unit Y once per month to receive patients from anywhere else in hospital X, usually from the emergency department. The nurses also referred to this period of time as: 'the unit was on call'. |
| Out-patients clinic: | refers to a walk-in unit attached to the hospital where patients with the chronic disease come on a regular basis (e.g., once per week, once per month) to have blood tests done, be examined by the specialist, and receive medications. Also referred to as 'the clinic'. |
| Part-time: | refers to being hired on a regular basis for an incomplete complement of work (e.g., working two days per week, usually on the same unit). |

| | |
|---|---|
| Personnel: | refers to other people working within hospital X (e.g., doctors, x-ray technicians, laboratory technicians, dietary staff). |
| The program: | refers to the three classes which the nurses taught over a period of two weeks. |
| Program coordinator: | refers to one of the teaching nurses who was appointed by the first head nurse to coordinate the program. This nurse, therefore, had two roles, teaching nurse and coordinator. |
| Relief nurse: | refers to a nurse working on unit Y for a shift who was not part of the regular full-time or regular part-time complement of staff nurses on unit Y. Also used in reference to a regular staff nurse from unit Y being sent to a short staffed unit elsewhere in hospital X to work a shift. |
| Shift: | refers to the period of time worked by a nurse at any one given time (e.g., a 12-hour shift, an 8-hour shift). |
| Staff nurse: | refers to the position filled by a registered nurse. This position reports to the head nurse. |
| Teaching module: | refers to the package of materials which the nurses developed. The package typically contains lecture content, teacher content, and directions on using learning materials in the class room setting. Also referred to as the 'teaching unit'. |
| Teaching nurse: | refers to a staff nurse on unit Y who volunteered to teach the program and who became one of four nurses on the teaching team. |
| The 'Trial Run': | a name given, by the first head nurse, to the first times the program would be taught. The first program was taught five times between June and November 1983. This period is the Trial Run. |
| The unit: | refers to the physical setting for 20 or more patients and 15 or more nurses. Also referred to as 'the ward' or the 'nursing unit'. |

## Organization of the Document

The document is organized into ten chapters. In Chapter 1, the purpose and significance of the study were presented. A brief review of the literature on the change process in health care settings provided evidence that the study was needed. A brief review of literature from interdisciplinary areas, particularly the area of education, revealed a list of the constructs and elements of the domain of planned change from which seven sub-questions to guide the study were generated. Furthermore, limitations bounding the study were delineated and terminology used throughout the study was defined.

In Chapter 2, the inductive approach to the inquiry and the qualitative methods employed to collect and analyze the data are discussed. In addition, the Provus Pittsburgh Evaluation Model is described to illustrate how additional probes for responsive questioning were derived.

Chapter 3 describes the context of the setting in which the study was conducted.

Chapters 4 through 8 provide in depth evidence in the form of document, interview, and field note excerpts about what happened, from the perspective of the informants, as the teaching program was developed and implemented. Five chronological stages evolved during the two year period during which data were collected.

In Chapter 4, the adoption/initiation period is discussed. Chapter 5 chronicles what happened between the period of adoption and implementation of the first program. During this period the nurses discussed their concerns about being involved in mounting the program.

What happened when the nurses implemented the teaching program the first five times (The Trial Run) is documented in Chapter 6. In Chapter 7, the way in which the nurses finally attempted to develop the teaching program is reported. Chapter 8 describes how the nurses then implemented the new program that they had planned and developed.

A discussion of the findings, tentative conclusions and hypotheses which began to evolve about the process of change as the study progressed is presented in each of Chapters 4 through 8 in addition to a description of the events that occurred. In each of the five chapters, the tentative conclusions and hypotheses are also compared to the literature in an attempt to support or refute published findings about the process of change.

The reactions of the staff nurses on unit Y, who were not involved in teaching the program, the doctors on unit Y, and the patients who took part in the program are described in Chapter 9. These reactions are cautiously regarded as formative outcomes of implementation of the program. Finally, in Chapter 10, a summary of the findings and conclusions is presented. Recommendations are discussed and reflections of the investigator about the inquiry are presented.

'Advance organizers,' intended to guide the reader, are provided during the introduction to many of the chapters. Throughout the document, the data "does the speaking". The process under study was long and complex. The study itself was long and complex and necessarily, the document is long and complex.

# CHAPTER 2

# CONDUCTING THE INQUIRY

## Introduction

The purpose of the study was to examine a single case of the process of change in a health care setting, specifically to describe and analyze the development and implementation of a teaching program for patients with a chronic illness on one unit in one particular hospital. Twenty-eight informants, over a period of two years, described their experience while the program was developed and implemented.

The chapter begins with a discussion of the rationale for the approach to inquiry, followed by a description of the structure or research design of the inquiry. Next, methods to establish reliability and validity of qualitative research are identified. Finally, a step by step account of the procedures used, to initiate the study and to collect and analyze the data, is reported.

## Approach to the Inquiry

The approach chosen for the inquiry about the change process could be described as inductive, exploratory/heuristic, responsive/naturalistic, artistic, emic, and/or a case study. According to Kaplan (1964:149) the heuristic type of experimental observation is designed to ". . . generate ideas, to provide leads for further inquiry or to open up new lines of investigation." One special kind of heuristic experiment is exploratory, it ". . . invites serendipity" (Kaplan, 1964:149).

A naturalistic approach in Guba's (1981:55) view, relies on field study and views truth as inescapable, "Sufficient immersions in and experience with a phenomenological field yields inevitable conclusions about what is important, dynamic, and pervasive in the field." Of the artistic approach, Eisner (1981:7) writes: "Artistic approaches to research are less concerned with the discovery of truth than with the creation of meaning."

The emic approach, according to Ragucci (1972:315) is ". . . an attempt to discover and describe the behavioral system of a given culture in its own terms." Harris (1968:571) describes the emic approach as:

> . . . logico empirical systems whose phenomenal distinctions or 'things' are built up out of contrasts and discriminations significant, meaningful, real, accurate, or in some other fashion regarded as appropriate by the actors themselves.

MacDonald and Walker (1974:181) thought the case study was the most appropriate approach to examine 'an instance in action,' in particular, "the experience of the participants and the nature and variety of transactions which characterize the learning milieu of the programme." They (MacDonald and Walker, 1974:181) explained: "There seems to be a need to find ways of portraying this experience and this milieu so that prospective users of new programmes can relate them to their own experience, circumstances, concerns and preferences." For MacDonald and Walker (1974:182) the case study was ". . . the way of the artist, who achieves greatness when, through the portrayal of a single instance locked in time and circumstance, he communicates enduring truths about the human condition."

As far as Stake (1978:7) was concerned the case study was particularly useful for ". . . adding to existing experience and humanistic understanding." He (Stake, 1978:7) described the features of the case study:

> 1. Descriptions are complex, holistic, and involve a myriad of not highly isolated variables.
> 2. Data are gathered at least partly by personalistic observation.
> 3. A writing style is used that is informal, perhaps narrative, possibly with verbatum quotations, illustrations, and even allusion to metaphor.
> 4. Comparisons are implicit rather than explicit.
> 5. Themes and hypotheses may be important, but they remain subordinate to the understanding of the case.
> 6. The characteristics of the method are usually more suited to expansionist rather than reductionist pursuits.
> 7. The case study proliferates rather than narrows.
> 8. The case study attends to the idiosyncratic more than to the pervasive.

According to Bogdan and Biklen (1982:58), a case study is ". . . a detailed examination of one setting, or one single subject or one single depository of documents, or one particular event." Even Campbell (1978), best known for his endorsement of the traditional experimental approach, became cognizant of the need for a more responsive approach to inquiry, recommending a case study be used.

While the inquiry in the present study does exhibit features of the aforementioned approaches, for the purpose of the present study, the approach selected is a descriptive case study utilizing qualitative procedures for data collection and analysis. The approach was chosen to examine meaning in the context of the event and minimize what Mishler (1979:3) described as ". . . context stripping procedures."

The qualitative approach, is an umbrella term which refers to several research strategies that share certain characteristics (Bogdan and Biklen, 1982:2). The characteristics are that: the natural setting is the direct source of data, the researcher is the key instrument, the researcher is concerned with context, the research is descriptive, the researcher is concerned with process rather than simply with outcome or products, data are analyzed inductively and 'meaning' is of essential concern.

Das (1983:301) suggested that qualitative methods are:

> . . . a 'pot-pourri' of interpretive techniques . . . including participant observation, ethnography, case studies, projective techniques, role plays, cartoon completion, contrived and unobstrusive observations and focused group interviews.

He explained that: (Das, 1983:301)

> Qualitative methodology combines the rational with the intuitive approach to knowledge, the focus in many qualitative studies typically is on the unfolding of process rather than structure. Qualitative approaches lend themselves better to the production of serendipitious findings and are in many cases broader and more holistic in perspective than quantitative tools.

This approach to the inquiry about the change process was selected in response to a weakness identified in most organizational studies by Van de Ven and Ferry (1980:2):

> . . . most of the information systems used in practice and those created by organizational researchers for their studies are not designed to provide a clue why or how a given level of performance was achieved.

The qualitative approach seemed an appropriate method of inquiry to respond to Van de Ven's concerns and its use was advocated across a variety of fields of inquiry. Das (1983:303), from the field of mangement studies, supported the use of the qualitative approach when studying organizations, suggesting, "There is an increasing preference today for a more holistic view of organizational behavior."

Eisner (1981:9) from the field of education discussed the recent interest in qualitative research, "Interest in 'qualitative research' is symptomatic of the uneasiness that many in the research community have felt with the methods of inquiry promulgated by conventional research tradition." Miles and Huberman (1984:21-22), also from the field of education and both with particular interest in planned change and innovation, discussed the attraction of qualitative data:

> Qualitative data are . . . a source of well-grounded, rich description and explanation of processes occurring in local contexts. With qualitative data, one can preserve chronological flow, assess local causality, and derive fruitful explanations. Serendipitious findings can appear.

Swanson (1982:242), from the field of nursing suggested, "Qualitative research, by its very nature, is applicable to nurses in practice settings," and she concluded that:

> . . . qualitative research provides a way to construct meaning that is more reflective of the world of practice because its methodology, like its subject, is more organic than mechanistic and, therefore, more suitable to the study of the domain of professional nursing (Swanson, 1982:245).

Particular insights about the 'nature' of qualitative research and about the 'methodologies' of qualitative research are provided in the following sections.

## Design of the Inquiry

The design of the inquiry was guided by the Provus Pittsburgh Evaluation Model (1973) for program evaluation. The model met the inquiry criteria advocated by: organizational theorists who subscribed to a multidimensional approach to examine organizations (Walker:1970, Mott:1972, Steers:1977, Kraegal:1980, Lawler:1980, Marshall:1980, Van de Ven:1980, Moorhead:1981); educational theorists who searched for the 'meaning' of change (Berman:1980, Leithwood:1981, Lieberman:1982, Fullan:1982, Hall and Loucks:1982); health care theorists who examined 'planned change' (Spradley:1980, Mauksch:1981, Lancaster:1982), and health care evaluators who examined program effectiveness (Suchman: 1967; Donabedian:1969, Bloch:1975, Luker:1981).

According to Provus (1973), the Pittsburgh Evaluation Model is comprised of four stages through which the inquiry progresses. Stage I, 'definition,' involves documenting a description of the program. In Stage II, 'installation,' the implementation of the program is observed. Stage III, described as 'process,' involves assessing the initial effects of the program, adjusting further treatments based on analysis of interim product data, and achieving a greater understanding as to the relationship between the program outcomes and the conditions of the treatment. In Stage IV, referred to as 'product,' the evaluator concludes whether the program has achieved its intended objectives.

By conceptually 'laying the theory of the change over the Provus model,' the seven research questions listed at the end of Chapter 1 were incorporated into a list of additional questions generated by the Provus model. The questions, which appear in Appendix A (Tables 1 through 4), were intended to be used as possible probes during the unstructured responsive interviews which were conducted. The probes were intended to be used only after an informant had introduced and exhausted a particular topic.

Before discussing the specific methodologies and procedures used in this qualitative case study, a discussion of the reliability and validity problems is appropriate.

## Reliability and Validity

Central to any kind of research are the issues of reliability and validity. As LeCompte and Goetz (1982:31) state, "The value of scientific research is partially dependent on the ability of individual researchers to demonstrate the credibility of their findings." Guba and Lincoln (1981:103) echoed similar thoughts about the need to assess the "trustworthiness" of naturalistic inquiry and stated, "For naturalistic inquiry, as for scientific, meeting tests of rigor is a requisite for establishing trust in the outcomes of the inquiry."

In the traditional research community, the most commonly referred to 'tests of rigor' are those developed by Campbell and Stanley (1963). These are internal and external reliability and internal and external validity. However, most researchers argue, as do LeCompte and Goetz (1982:32), that the techniques used by qualitative researchers to address questions of credibility differ from those used by traditional researchers in that data gathering necessarily precedes hypothesis formulation and the subjective experiences of participants are admitted into the data.

Two pairs of writers, Guba and Lincoln and Miles and Huberman have recently attempted to develop and describe these 'different techniques.' Guba and Lincoln (1981:103-127) presented the 'naturalistic analogues' of: truth value, applicability, consistency, and neutrality, as alternatives to be used when thinking about the four major criteria of rigor in scientific inquiry.

Miles and Huberman (1984:23-28), suggested that the ways in which qualitative researchers develop and describe their techniques for data analysis were the areas most troublesome to the credibility of qualitative research. They discussed the activities which occurred during data analysis, as being: data reduction, data display, and drawing and verifying conclusions; and identified techniques to be used during the three activity periods which would increase the credibility of the findings.

The techniques for addressing the issue of credibility as described by LeCompte and Goetz (1982) were judged to be the most appropriate for use in the present study. These techniques are discussed in the following two sub-sections. While designing the procedures for data collection and analysis, the investigator kept in mind the techniques which LeCompte and Goetz had suggested might enhance reliability and validity so that the findings from the present study could be viewed by the reader with credibility or 'trust.' The problems of reliability and the techniques suggested by LeCompte and Goetz to enhance credibility of the findings are discussed below.

## Reliability

According to LeCompte and Goetz (1982:35), reliability refers to ". . . the extent to which studies can be replicated. It requires that a researcher using the same method can obtain the same results as those of a prior study."

However, because unique situations cannot be reconstructed precisely and because human behavior is never static, LeCompte and Goetz (1982:35) explain that ". . . no study can be replicated exactly, regardless of the methods and designs employed."

Two kinds of reliability are of concern to the researcher, external and internal.

External reliability. According to LeCompte and Goetz (1982:32), "External reliability addresses the issue of whether independent researchers would discover the same phenomena or generate the same constructs in the same or similar settings." They suggest that ethnographic research attempts to approach rather than attain external reliability. Five major problems were identified by LeCompte and

Goetz (1982:37-40) which threaten external reliability and which should be recognized and handled by the researcher. The problems were: (1) researcher status position, (2) informant choices, (3) social situations and conditions, (4) analytic constructs and premises, and (5) methods of data collection and analysis.

Internal reliability. According to LeCompte and Goetz (1982:32), "Internal reliability refers to the degree to which other researchers, given a set of previously generated constructs, would match them with data in the same way as did the original researcher." The problem is especially critical when multiple researchers and multiple sites are involved in the study. Interobserver realiability is crucial to internal validity. LeCompte and Goetz (1982:41-43) identified five strategies to reduce threats to internal reliability. These strategies were: (1) low-inference descriptors, (2) multiple researchers, (3) participant observers, (4) peer examination, and (5) mechanically recorded data.

## Validity

LeCompte and Goetz (1983:32) suggest that validity:

> . . . is concerned with the accuracy of scientific findings. Establishing validity requires determining the extent to which conclusions effectively represent empirical reality and assessing whether constructs devised by researchers represent or measure the categories of human experience that occur.

They (LeCompte and Goetz, 1982:43) suggest that, "Although the problems of reliability threaten the credibility of much ethnographic work, validity may be its major strength."

Two kinds of validity are of concern to the researcher, internal and external.

Internal validity. Internal validity refers to ". . . the extent to which scientific observations and measurements are authentic representations of some reality (LeCompte and Goetz, 1982:32)." They (LeCompte and Goetz, 1982:44-50) identify five threats to internal validity which are: (1) history and maturation, (2) observer effects, (3) selection and regression, (4) mortality, and (5) spurious conclusions.

External validity. "External validity addresses the degree to which such representations [the claim of authentic representation of a given reality] may be compared legitimately across groups (LeCompte and Goetz, 1982:32)." External validity therefore depends on the identification and description of those characteristics of phenomena salient for comparison with similar types. LeCompte and Goetz (1982:51-54) identified four factors which may affect the credibility of a study for cross-group comparisons or generalizability. The factors were: (1) selection effects, (2) setting effects, (3) history effects, and (4) construct effects.

Throughout the remainder of the chapter, the role of the researcher is presented and the procedures that were used in the study are described. Throughout the remainder of the report, the reader is taken along and discovers as the researcher did, in some instances at the same point in the narrative, when findings, themes, constructs, tentative conclusions and tentative hypotheses began to emerge. This is accomplished by the use of generous interview excerpts, document excerpts, and field note excerpts. In addition, factor tables, event tables, process figures, tables of tentative conclusions and hypotheses and construct configuration figures are presented in an attempt to illustrate what happened, when it happened. The tables and figures are provided to give the reader a sense of the process of data collection and analysis and the process of change as it occurred.

## Initiating the Inquiry

### Selecting the Setting

In August of 1982, the investigator, who is a nurse (Appendix D) was introduced to the head nurse of unit Y, hospital X, at a professional nursing conference. Agar (1980:30) refers to this as 'the colleague connection.' During the course of discussions, the investigator learned that a proposal was being prepared by the head nurse to request approval and funding to develop and implement a teaching program for the chronically ill patients on unit Y. According to Agar (1980:29), unit Y would be the 'bounded community.'

The investigator let it be known that she was commencing a doctoral program one month later (September, 1982), was interested in the areas of planned change, organizational effectiveness, and program evaluation, and was open to suggestions about a setting in which to conduct an inquiry. An invitation was extended by the head nurse to visit the unit and to discuss the feasibility of conducting a study if the proposed program was approved and funded.

Between September 1982 and July 1983, the investigator visited unit Y nine times to conduct what Bogdan and Biklen (1982) describe as an exploratory assessment of what is feasible or what Rutman (1980) calls an evaluability assessment. Bodgan (1982:57) suggests choosing a setting which is convenient and one in which the investigator is not directly involved, that is in which the investigator will be considered a neutral observer.

Schatzman and Strauss (1973:19) suggest the researcher "cases the joint" carefully for three reasons:

> (1) to determine as precisely as possible whether this site does, in fact, meet his substantive requirements - a question of 'suitability'; (2) to 'measure' some of its presenting properties (size, population, complexity, spatial scatter, etc.) against ones own resources of time, mobility, skills, and whatever else it would take to do the job - a question of 'feasibility'; and (3) to gather information about the place and people there in preparation for negotiating entry - a question of 'suitable tactics.'

While discussing the question of 'suitable tactics,' Schatzman and Strauss (1973:20) commented, ". . . to know in advance of negotiation about the routines, social structure, crises, and the realities of factionalism is to be at a considerable advantage in the negotiation that must follow."

In the fall of 1982, the head nurse of unit Y invited the investigator and her supervisor to conduct a study to examine the satisfaction of staff nurses on unit Y. Data for this study were collected during January and February of 1983. While collecting data for the satisfaction study, the investigator assessed the following factors which would be important in her own study: convenience, neutrality, access, support, availability/willingness of informants, stability of informants, acceptance/trust and procedures to be used while conducting the study.

The setting was convenient. The hospital was accessible to the investigator. Parking was available. Physical access to unit Y was easy and could be unobtrusive. Six private areas for conducting interviews were in close proximity to the unit.

The investigator considered herself to be neutral in the setting. She had never worked in hospital X, nor had she previously worked with any of the nurses in a nursing capacity although the head nurse and one part-time staff nurse had met the investigator at numerous professional nursing functions.

Ease of access was important to assess in this study. The investigator had heard rumors that the institution had a reputation of cautiously allowing external researchers into the hospital. The head nurse was a member of the hospital nursing research committee and she freely outlined the required steps to be taken in order to gain official access. Contact was made with the chairperson of the nursing research committee, whom the investigator had met on previous occasions in a professional capacity. Required forms and guidelines were obtained and assessed for congruence with the objectives of the study and requirements of the investigator. The investigator felt confident that access would not be blocked.

One of the key requirements of the investigator was that support of two kinds, people and resources was forthcoming. Support of the head nurse and nursing administration (gatekeepers) was paramount. Also of consideration was whether the head nurse could/would act as the mediating individual (Agar, 1980) between the investigator and the institution. The head nurse met with one of the directors of nursing to discuss the possibility of allowing the study to be conducted on unit Y. The investigator then requested a meeting with the head nurse, the director of nursing, and the dissertation chairman. The strategy resembles Miller's (1979) 'hub-spoke method' of initiating change. The director of nursing supported the idea of the study. Thus, the investigator concluded that key people supported the study.

The second key support required was that of resources. A preliminary cost estimate indicated the study would cost between five and six thousand dollars. During subsequent meetings between the head nurse, occasionally the director of nursing, and the investigator, it became clear that certain resources (tape recorder, transcriber, printing services, typing services) might be available, while others, namely funds, would not. The investigator concluded that resources could not be guaranteed to be forthcoming from this setting and that contingency plans would be necessary.

The availability and willingness of informants to participate in the study were of key importance because it was anticipated that the study would last at least one year. Assessment occurred during visits to the unit over the ten month period. Daily work patterns (report times, nurses' rounds, admitting times, physiotherapy routines), weekly work patterns (doctors' rounds, committee meetings, head nurse meetings, staff meetings, in-service education programs), and special event patterns (grand rounds, summer holidays) were observed and/or discussed with the head nurse.

In addition, the nurses were observed for behaviors which indicated a willingness to participate (interest, courtesy, inclusion, acknowledgement, seeking-out, confiding, and commitment). Two mandates of the unit were to initiate, conduct, and participate in research activities and to participate in planned change activities. Based on the behaviors exhibited by the nurses and the mandates of the unit, the investigator concluded that informants would be available and willing to participate.

In addition to being available and willing, the informants had to be stable, that is remain on the unit for the year. Manpower turnover in nursing is historically high. However, because the unit was relatively new, established in 1982, and because each nurse had been individually selected by the head nurse to particpate in realizing the mandate of the unit; the investigator concluded that the informants could be expected to remain in the setting for the one year during which the study would be conducted.

Acceptance of the investigator into the setting was one of the most crucial factors to be assessed (Guba, 1981). At the end of the ten month assessment period, behaviors of inclusion and confiding on the part of the head nurse became predictable. In addition, behaviors of acknowledgement, courtesy, and interest on the part of the staff were apparent. The investigator thought that she would become accepted and trusted by the nurses in the setting.

Finally, by the end of the ten month period, the investigator had identified some procedures to be used. It was determined that documents would be available, that unstructured tape recorded interviews could be conducted and that field notes could be collected. In addition, a picture of the sampling plan began to develop. Four staff nurses who had volunteered to teach the program and the head nurse would be the key informants, particularly during the initial period of the study.

In January of 1983, the head nurse received approval and funding to develop and implement the teaching program. The investigator tentatively selected unit Y as the setting in which to conduct the present study. However, official entry still had to be negotiated.

### Gaining Official Entry

Gaining entry was a critical dimension to the success of the study. During the assessment activities to select the setting, the investigator was overt, honest and kept a low profile (Bogdan and Biklen, 1982:121-125). These were the beginning steps of establishing a trusting relationship with the participants. Gaining official entry however, required more formalized activities.

A proposal in accordance with institutional guidelines, complete with an informed consent form (Appendix B) and a letter of support from a doctor on unit Y (Appendix C) was submitted to the nursing research committee of the hospital. On May 19, 1983, the investigator attended a meeting to discuss the proposal with the committee members.

The proposal to conduct the study was approved in principle, with only minor revisions suggested, in May of 1983, by the nursing research committee. Revisions were made and the proposal was submitted to the hospital research committee. A letter of support was received from a director of nursing. Finally, in early July, letters of approval to conduct the study were received from the hospital research committee on the condition that the identity of the hospital, the unit, the kind of teaching program, and the participants would remain confidential.

Bodgan and Biklen (1982:122) caution that gaining formal approval can be a long, laborious process and that it is smart to begin negotiations well in advance of the projected starting date. Ten months had elapsed between the time the investigator first visited the unit and the time that official approval to conduct the study was received.

## Process of Data Collection

Based on findings from the assessment period and on the literature about the qualitative approach and field methods, and based on the developmental nature of the process under study, the investigator determined that the process of data collection should be allowed to evolve or unfold rather than be predetermined in rigid detail. However, it was essential that the investigator should be flexible, come to the data collection period 'armed' as it were with a tool box full of possible procedures and techniques and with the knowledge and skill required to use each procedure as the situation demanded.

A variety of data sources were used: documents, interview tapes, field notes, diaries, and summaries of telephone calls. Many additional informants emerged as the study progressed: staff nurses, head nurses, teaching nurses, doctors, a physiotherapist, patients, supervisors, and directors. A variety of sampling plans were used: a population, a convenience sample, a stratified sample, a purposive sample and a snowball sample. Data collection procedures were implemented as required: document collection, unstructured interview, semi-structured interview, and observation.

Throughout Chapters 4 to 8, the need for additional data sources will be identified as they were required and utilized. Data were mainly collected in three forms: documents made available to the investigator, in-depth unstructured interview tapes, and field notes. This triangulation of data sources was necessary to create an accurate picture of the process of change as it emerged. Jick (1979:603) advocated the use of triangulation of data sources:

> Triangulation, however, can be something other than scaling, reliability, and convergent validation. It can also capture a more complete, holistic, and contextual portrayal of the unit(s) under study. That is, beyond the analysis of overlapping variance, the use of multiple measures may also uncover some unique variance which otherwise may have been neglected by simple methods. It is here that qualitative methods, in particular, can play an especially prominent role by eliciting data and suggesting conclusions to which other methods would be blind. Elements of the context are illuminated. In this sense, triangulation may be used not only to examine the same phenomenon from multiple perspectives, but also to enrich our understanding by allowing for new or deeper dimensions to emerge.

### Documents

Letters and memos coming to or leaving unit Y about the teaching program were collected by the investigator, who in turn, made a photocopy of each document. In addition, copies of draft working papers, draft proposals and draft and final position papers were collected by the investigator.

The documents, proved to be a valuable source of data for a number of reasons. First, because the study was developmental, the events which occurred and the process which unfolded could be tracked through time via the documents. Second, the documents could be used to corraborate information given by the informants and vice versa.

At one point during the study period, the investigator was the one person who had a complete set of documents about the program. The head nurse of unit Y resigned leaving an acting head nurse in charge of unit Y and a program coordinator in charge of the teaching program. The investigator's knowledge about the documents was of slight assistance to the program coordinator. More important, from the perspective of the study, a complete set of documents was 'in hand' before the 'change over' in unit leadership occurred. Excerpts from the documents and in some instances complete documents appear in Chapters 4 through 8.

### Interviews

In order to answer the general question of "What happened?" and in keeping with the inductive, emic, naturalistic characteristic of the study approach, the unstructured interview was judged to be the most appropriate method of data collection. According to Bogdan and Biklen (1982:135), the interview is used to ". . . gather descriptive data in the subjects own words so that the researcher can develop insight on how subjects interpret some piece of the world." Das (1983:308), believed the aim of the depth interview was to ". . . identify a respondent's attitudes, motives and behavior by encouraging the person to talk freely and to express his or her ideas on the subject matter under discussion."

Guba (1981:157) believed the unstructured interview was the most appropriate of the interview methods "to search for multiple realities, truths, and perceptions." Reiterating Dexter's (1970:3) definition of the unstructured form of interviewing, Guba (1981:156) commented:

> . . . it involves: stressing the interviewee's definition of the situation, encouraging the interviewee to structure the account of the situation; and letting the interviewee introduce to a considerable extent his notions of what he regards as relevent, instead of relying upon the investigator's notion of relevance. Thus, unlike a structured, focused, or standardized interview, the unstructured or "elite" interview is concerned with the unique, the idiosyncratic and the wholly individual viewpoint.

Interview Protocol. Two pilot interviews were conducted in April and May, 1983. Based on those interviews, the following guidelines for interviewing were developed. Interviews would be taped rather than hand recorded. Individual rather than group interviews would be conducted. In most cases, the interview would last no longer than one hour.

Interviews on unit Y were usually conducted on a Thursday or Friday afternoon. In most cases, only one interview per week was conducted with a staff member from the unit. Finally, permission to interview was usually requested from the head nurse and the informant one day prior to each interview and the precise time for the interview was confirmed at noon on the day of the interview.

Forty-six interviews were conducted in one of six private areas in close proximity to unit Y. Four interviews were conducted in the informant's office. Nine interviews were conducted in the informant's home. One interview was conducted in the investigator's office.

Forty-six unstructured interviews and 14 semi-structured interviews were conducted. The semi-structured interviews were conducted later in the study period, the structure having emerged from analysis of data collected earlier in the study.

A Sony Taperecorder TC-110B with external microphone was used. The taperecorder was kept unobstrusively on a chair beside the investigator and within eyesight. The external microphone rested on a table or chair, around which the informant and investigator gathered. Sony LNX60-90 minute tapes were used. Each tape was tested, dated, and numbered prior to recording. Sections of tape in which informants were not identified were regularly reviewed by the dissertation chairman to assess interviewing techniques.

The tapes were transcribed verbatim by a secretary who was external to hospital X. In total over 1,300 pages of transcripts were collected. Three copies of each transcript were made for coding. Two copies were kept at the investigator's home. The original copy was kept in a location away from the investigator's home.

A total of 60 interviews with 28 informants were conducted between April 1983 and September 1984. Each informant signed an informed consent prior to being interviewed. (Appendix B). In order to assure anonymity of the key informants (the four teaching nurses) their names were changed to Beth, Ruth, Marg and Ann. The head nurse was not referred to by a name. To assure anonymity of the hospital and the unit, and to avoid a slip of the tongue, the investigator immediately began to refer to hospital X and unit Y in all interviews and all conversations about the study.

Interviewing technique. Each unstructured responsive interview with the key informants began with a general question. What happened this week? What was this week like? Tell me your story? As the excerpts contained in Chapter 4 through 8 demonstrate, the informants needed little else to 'get them started.' In some instances, the investigator was slow in starting the tape recorder and often had to paraphrase the opening remarks of the informants.

Throughout each interview, a variety of interviewing techniques were used. After an informant had raised a topic of discussion and exhausted the topic, probes were used to collect the in-depth data. Seven general questions had been generated to guide the data collection period, in addition to the probes which had been generated from the Provus model (Appendix A). However, it must be emphasized that the investigator did not use these probes during the entire data collection period. This is not to suggest that the predetermined probes were not useful or did not influence the collection of data. It is to suggest that the predetermined probes did not control what data was collected or what topics were discussed during the interview.

Rather, the interview process was as follows. The informant introduced and discussed a topic. The investigator initially responded to verify or clarify facts, to elicit thicker description, to paraphrase what the informant had said, or to directly reflect what the informant had said.

About 15 minutes into the interview, the informant had generally raised a number of topics which the investigator wanted to probe more deeply. Because the investigator took no notes during the interview, keeping the responsive probes 'in her head' proved to be difficult and fatiguing. About five probes could be kept 'in her head' at any one time.

The investigator was relieved when the informants were occasionally called out of the room to admit a patient, weigh a patient, transfer a patient from stretcher to bed, or to take a phone call, for this allowed her time to 'collect her thoughts' and 'jot' down the probes she wished to pursue.

As each interview progressed and particularly as the interviews with each informant progressed over the two year period, the form of responsive interviewing changed. Facts were still verified. However, facts were now verified that one informant had given in one interview or over a series of interviews and facts were verified across informants over extended periods of time.

In the later months of the study, while probing and paraphrasing were still the mainstay of the interviewing repertoire, additional tactics were used as suggested by Schatzman and Strauss (1973:81). These included the 'devil's advocate question,' the 'hypothetical question,' 'posing the ideal' and offering 'interpretations or testing hypotheses.'

An example of the 'devil's advocate' question was:

> I: I'm going to play the devil's advocate here. You've been telling me that the doctors are not interested in this

> program. Yet you're now telling me that they are talking about the program throughout the country. How do you explain that?"

An example of the 'hypothetical question' was:

> I: You've been talking about the problem of leadership. What would happen if a leader was brought in from outside of the unit?

An example of 'posing the ideal' was:

> I: We've been discussing all the problems that occurred with trying to implement this program. You've suggested that the acting head nurse was not interested in the program. Let me play the role of the acting head nurse for a couple of minutes. Should I as acting head nurse meet with you four teaching nurses every week to discuss the program?

Two examples of 'offering interpretations' or 'testing an hypothesis' were:

> I: Throughout the last 20 minutes while we've been talking I've had the feeling that you are very disillusioned about the program. Am I right?
>
> or
>
> I: Throughout the last three months I've had the feeling that you teaching nurses have not known how to solicit feedback from the patients or what feedback to solicit. How does that strike you? Am I way off base, out in left field somewhere?

The investigator cautions, however, that the above four tactics, particularly the 'devil's advocate question' should be reserved for a time when interpersonal familiarity, comfort, acceptance and trust have been well established between the investigator and the informant.

As the number of interviews with the key informants increased, the investigator developed other tactics of note. First the investigator learned to pace the interview. Informants often talked quickly, slurred words together, or talked in split sentence format. Tapes from these interviews were very difficult to transcribe (the secretary requested that something be done), and transcripts were difficult to read and edit. By talking slowly, enunciating clearly and attempting to respond in complete sentences, the investigator observed that the informants attempted to do the same.

Second, because the investigator was taking no notes during the interview, she could not 'jot down' the themes that literally 'popped' out during an interview. To prevent losing the theme at that time, the theme word was used in the responsive paraphrase. In addition to having captured the theme on tape, this tactic allowed the informant to corroborate or negate the theme.

> I: I'd like to try to summarize that to see if I've got it right. You're saying that the program coordinator won't use her authority to get things done.
>
> Staff nurse: Well maybe authority is the wrong word. I don't think she knows how to be a leader.
>
> or
>
> I: From what you're saying am I right in understanding that you teaching nurses had no knowledge and experience with doing this kind of thing before?
>
> Teaching nurse: You got it. That's exactly right. We had no idea what we were dong. We'd never done it before. We simply didn't know.

The examples of and list of tactics used throughout the study are endless. However, the preceding examples are given to illustrate the kind of interviewing repertoire that was required in the study and to alert the reader to the examples of responsive probing which appear later in Chapters 4 through 8.

The sampling plan. Traditional research approaches look upon the sample as some kind of guarantee of representativeness of the population. Agar (1980) suggests that the nature of the question should determine the sampling design, that representativeness should be of some concern, and that options between a probability sample and an opportunistic sample are available. Kaplan (1964:239) responds to concerns about representativeness by suggesting that ". . . representativeness is not a property of the sample but rather of the procedures by which the sample is obtained, the sampling plan."

The informants were selected according to a modified purposive sampling technique (Bogdan and Biklen, 1982). Four nurses volunteered to teach the program. These nurses along with the head nurse were the key informants. According to Bogdan and Biklen (1982:63), these are people who are ". . . more willing to talk, have a greater experience in the setting, or are especially insightful about what goes on." The area supervisor, the director of nursing service, one physiotherapist, five staff nurses, four doctors, nine patients, and two other head nurses emerged as informants as the data were being collected. According to Bogdan and Biklen (1982:67), "You choose particular subjects to include because they are believed to facilitate the expansion of the developing theory." Details on why and how these informants were chosen for interview are included in Chapters 4 through 9. In total 28 informants were interviewed.

## Field Notes

The field notes were a composite of notes about the interviews, memos, and diary inserts. Immediately upon completion of the interview, extensive field notes were made (Glaser:1978, Guba:1981, Bogdan and Biklen:1982). A brief summary of the interview was documented. Observations made by the investigator, questions which emerged for further investigation, and probes for further interviewing of the same informant or other informants were noted.

When signing the informed consent, each informant was told that from that time on, anything they said about the program, at any time, in any situation was 'on the record' unless they indicated otherwise. Notes were also kept about all contacts with informants regarding the program (e.g., telephone calls, chance meetings in the parking lot, conversations over coffee).

In addition, thoughts of the investigator about the study were written on a daily basis (Glaser:1978, Guba:1981, Bogdan and Biklen:1982). Impressions, 'gut-feelings,' emerging themes and constructs, and tentative conclusions and hypotheses were noted and inserted into the field notes. No record was kept of statements given in confidence or given 'off the record.'

The recording of field notes proved to be the first step in data analysis and supported the statements of Schatzman and Strauss (1973:109) that ". . . the systematic development of theoretical notes can be thought of as a preliminary analysis." Excerpts from the field notes appear in Chapters 4 through 8.

## Process of Data Analysis

As indicated in the preceding sections, data analysis began early during the period of data collection and continued on long after data collection was completed, thus supporting Bogdan and Biklen's (1982:56) idea that, "Although the most intensive period of data analysis occurs at the later stages, data analysis is an ongoing part of the research."

The approach to data analysis of Turner (1981), Glaser and Strauss (1967), and Bodgan and Biklen (1982) were researched and modified for use in this study. The analysis progressed through three phases.

### Phase One

Each transcript was checked against the tape for accuracy. Corrections were made. The name of the informant, position, interview number, and date was typed on each transcript page. Because the study was longitudinal and focussed on process, the transcripts were kept intact rather than cutting and pasting sections onto file cards.

Each sentence, or when appropriate each paragraph, within the transcript was analyzed and the emerging theme or construct was noted in the right hand margin. In the left hand margin, methodological issues were noted (types of interview questions asked, misunderstandings, ethical issues, need for further verification with other informants). Three files of data were produced.

In the first file, one summary sheet for each interview was developed. On the sheet, each theme or separate construct was listed. In total, 60 summary sheets were made, one per informant per interview.

At the same time, a set of file cards about the methodological issues were developed. Each card had a separate title (e.g., sampling plan, ethical issues, devil's advocate questions, reflection questions). The interview number and page number of the excerpt which corresponded to the card title was noted.

In addition to the file of summary sheets and the file cards, a third file was started. A set of summary sheets were developed which tracked the events which ocurred during the process according to chronological order. A modification of the sheets from this file appears at the beginning of each of Chapters 4 through 8.

### Phase Two

During phase two, each tape was again reviewed along with the transcript. Each summary sheet was reworked. Themes were labelled and constructs were sorted and placed under theme headings. New theme headings were developed for groups of constructs which fitted together but did not fit under one of the existing themes. In other words the major themes and the constructs of each theme had emerged from the data. What had started out as 60 summary sheets, now became 60 theme sheets, one theme sheet per informant per interview. Each theme sheet contained 12 or more themes.

### Phase Three

At this point in the analysis, a decision had to be made about the reporting format of the data. Would the report focus on themes which emerged or would the report document in chronological order the process which had occurred? The research question was reviewed and the problem discussed with the dissertation chairman. By mutual agreement, a reporting format was chosen to reflect process according to chronological order. The themes would be blended into the chronological framework.

Five somewhat distinct stages of the process according to chronology were evident in the data. The 60 theme sheets were divided into five groups, each group corresponding to one of the chronological time periods.

The theme sheets for each chronological period were laid out side by side. The number of theme sheets per time period ranged from three to 14.

A worksheet was designed to record the themes that held for one informant across all interviews and that held across all informants during the chronological period. It was from this kind of analysis that the 'initial concerns of the teaching nurses' emerged which are described in Chapter 5. Themes which did not hold for one informant across all interviews and which did not hold for all informants across the time period were noted at the bottom of the worksheet. At the conclusion of this phase, five work sheets which illustrated the themes within each stage of the process had been produced. Modified versions of the worksheets appear in the beginning of the discussion section of each of the Chapters 4 through 8. Also produced were a set of themes which were idiosyncratic to one particular informant, or one group of informants, and which were in some cases stage-specific or time-bound, that is they did not flow across all five stages.

At the same time that the summary, theme, and working sheets were being developed, data in the documents and the field notes were analyzed. In most cases the datum verified, clarified, or enlarged upon a theme which had emerged from analysis of the transcripts.

As with the process under study and the process of data collection, the process of data analysis was complex and required that design decisions be made at every step along the way. In the next chapter, the setting in which the study was conducted is described.

# CHAPTER 3

# THE SETTING AND BACKGROUND

In this chapter, the setting in which the study was conducted is described and a background of the history of the events on unit Y is provided.

## Unit Y

### Physical Setting of Unit Y

Unit Y was a 20 bed chronic care unit in a large Canadian hospital. The unit was spacious, bright, cheery, color coordinated, and contained modern equipment. Patient rooms (privates and semi-privates) were on the perimeter of the unit, with the nursing station and service areas concentrated in a central corridor. Three lounge areas, somewhat separated from the mainstream of unit activities, were provided for patients. Office facilities, also separated, were provided on the floor for the head nurse and the area supervisor. In addition, one conference room was attached to the unit and another one was situated further down the hall. In total, six private interview sites were available.

### Staff on Unit Y

The unit was to be staffed by 14 registered nurses, 12 working full-time and two working regular part-time. The ratio occasionally shifted. For example, in February of 1984, there were nine full-time and eight regular part-time registered nurses on staff. Of these, two of the staff nurses possessed a bachelor's degree, the rest a diploma in nursing. The criteria for the head nurse position was at least a bachelor's degree with a master's degree in nursing or a related discipline preferred. One unit clerk worked on the unit. An area supervisor included unit Y under her jurisdiction along with four or five other units. Four doctors, specialists in the care of patients with the chronic illness, serviced the unit. One of the doctors was designated as chief.

### Scheduling the Staff Nurses on Unit Y

A six week, 12 hour rotation was used to schedule the staff nurses for work on unit Y. Two senior nurses were removed from the 12 hour rotation and functioned as 'on-desk' or 'charge nurse' on days (when the head nurse was away) and on evenings (8-hour shifts).

### Patients on Unit Y

Unit Y serviced a large Canadian city and a major region of the province. Subsequently, the patients were geographically dispersed and came from both urban and rural settings. Patients who had been newly diagnosed with the chronic illness and those who were long term sufferers were admitted to the unit. The purpose of admission was to initially treat and stabilize or re-stabilize the patient with medications, physiotherapy, occupational therapy and teaching. Length of hospital stay was usually three weeks. The youngest patient on record as being admitted was 16 years of age. However, most of the patients would be categorized as young adults, middle aged or elderly.

The unit was regularly designated to be 'on take.' During this period each month, three to five beds were kept open to receive patients with any kind of illness who had been admitted to hospital.

## Philosophy and Objectives of Unit Y

The philosophy of the unit was based on the belief that a clinical environment dedicated to excellence in nursing would develop professional responsibility and accountability, would enhance feelings of professional and personal worth, and would promote the development of the professional potential of the nursing staff. The primary objective of unit Y was to provide care to a selected group of patients within the framework established by the philosophy of the hospital and the Division of Nursing. Unit Y provided a focus for systematic and goal directed development of staff in the areas of practice, administration, teaching, and research.

Specific objectives of the unit were to:

1. Provide an environment which could serve to instruct and inspire nurses in the pursuit of excellence in clinical nursing, nursing leadership, nursing education and nursing research.

2. Apply and teach the nursing process within a clinical environment of excellence and inquiry.

3. Serve as a focus for the development of skills in leadership, administration and change agentry among nurses who demonstrate initiative and creativity.

4. Develop and apply teaching models which are relevant to the needs of all levels of nursing personnel, and which provide opportunity for the development and application of teaching skills.

5. Advance nursing knowledge and practice through the systematic application of knowledge and the evaluation of a variety of approaches to patient care and nursing problems.

6. Recruit and retain nurses with high levels of motivation and skill within the Department of Medical Nursing.

7. Identify, develop, teach and study the unique and specialized aspects of medical nursing.

8. Integrate and apply knowledge from all areas of nursing practice to the care of medical patients in the unit.

9. Differentiate, develop and evaluate nursing roles and functions.

10. Stimulate and assist other nursing units in the development and application of nursing knowledge and skill.

## Unit Y and Hospital X

### Structure of the Nursing Department of Hospital X

The structure of the nursing department of hospital X is illustrated in Figure 3.1, a cut-away of the total organization. The chief executive nursing officer, who reported to the chief executive officer of the hospital, was responsible for nursing services within the hospital. The directors of nursing service reported to her. Each director of nursing service was responsible for an area of nursing such as surgical nursing, medical nursing, nursing education, rehabilitation nursing, quality control, and nursing research.

Area supervisors reported to each director of nursing service. They were each responsible for the nursing service provided on either five or six nursing units. Consequently, either five or six head

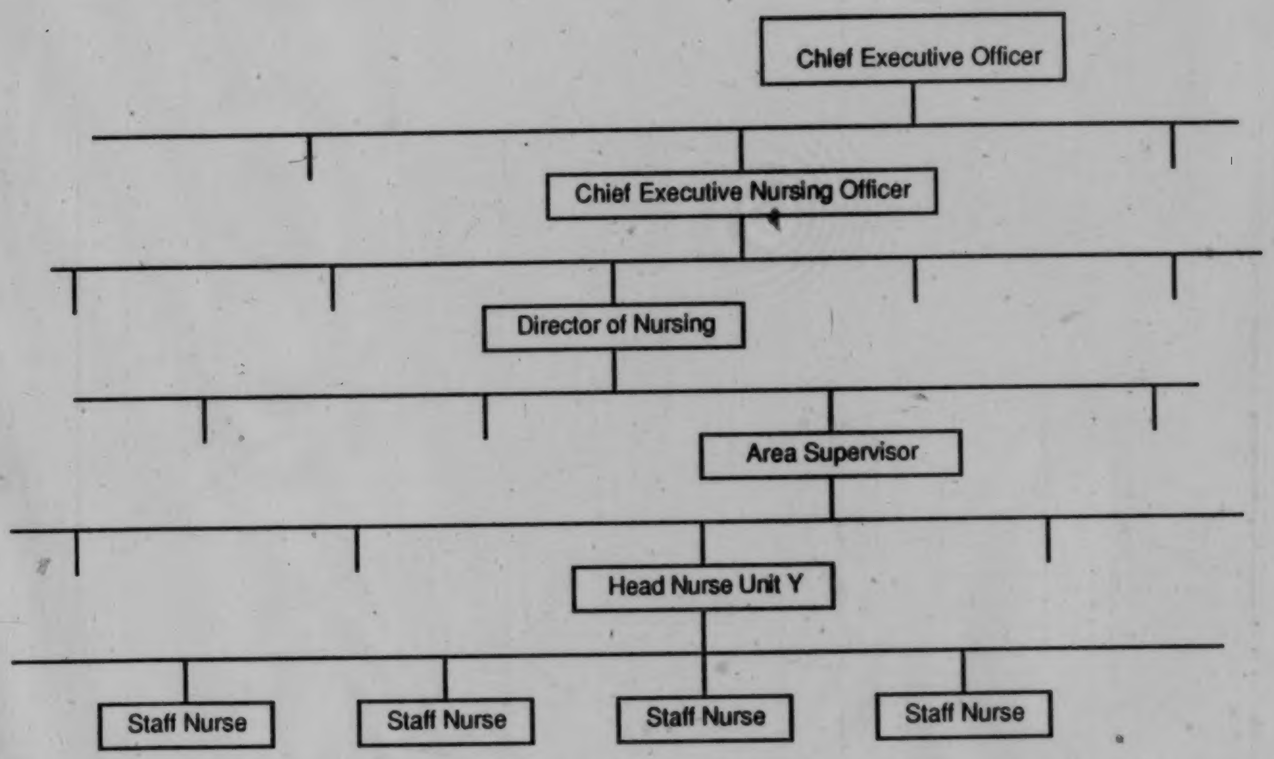

Chief Executive Officer
Chief Executive Nursing Officer
Director of Nursing
Area Supervisor
Head Nurse Unit Y
Staff Nurse
Staff Nurse
Staff Nurse
Staff Nurse

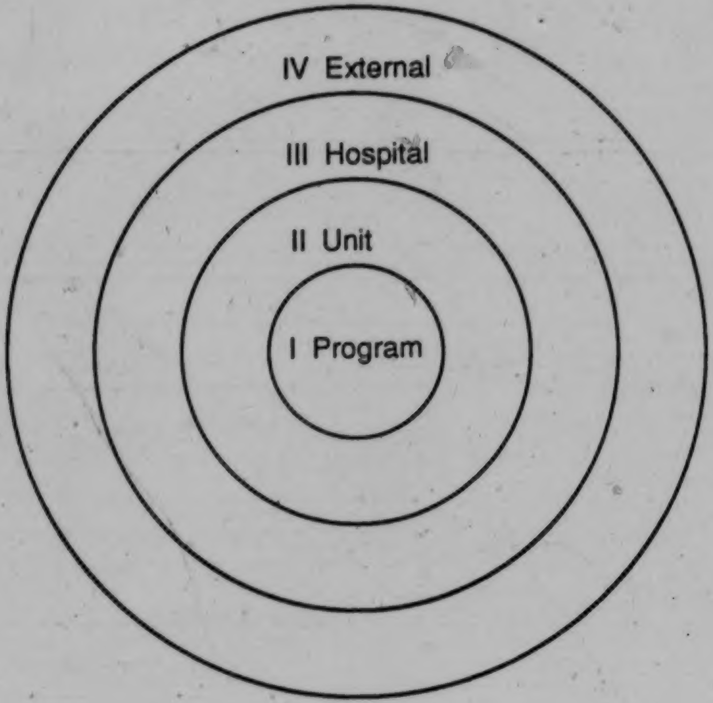
**Figure 3.1**

Structure of Nursing Department in Hospital "X" nurses reported to each area supervisor. Each head nurse was responsible for the service on her unit over a 24-hour period provided for 20 or more patients by at least 15 or more registered nurses, registered nursing assistants, ward clerks, ward aides, and unit managers.

### Unit Y Relationship

As far as the teaching program was concerned, unit Y liaised with a number of other hospital departments. The hospital departments of medicine, physiotherapy, pharmacy, occupational therapy, and social services, were of particular importance to the unit and to the program.

In addition, the activities of central administration, namely, the chief executive nursing officer, directors of nursing service, the area supervisor, and the finance department had an impact on the unit. Physically separated from the unit, but also of importance was the influence of the outpatients' clinic, which the patients may have attended before or after being admitted to the unit. Finally, the activities of a volunteer Association, whose mandate was to assist and support persons with the disabling chronic illness, influenced the unit. It was to this Association that the head nurse applied for funding to implement the teaching program. In summary a schema of the setting in which the development and implementation of the teaching program was to take place might look like Figure 3.2.


IV External
III Hospital
II Unit
I Program

I PROGRAM
- teaching nurses
- patients and families

II UNIT
- head nurse
- staff nurses
- doctors

III HOSPITAL
- chief executive nursing officer
- director of nursing
- area supervisor
- physiotherapy
- occupational therapy
- social services
- pharmacy
- out-patients' clinic
- finance department

IV EXTERNAL
- volunteer association
- clinics in rural areas

**Figure 3.2**

The Study Setting

## History

### Background of Unit Y

Prior to April 1982, unit Y had been part of a larger unit in another part of hospital X. The services provided on the larger unit had included a couple of other specialties in addition to the specialty specific to the chronic illness. A teaching program for patients with the chronic illness had been designed by one physiotherapist and had been delivered by the physiotherapy department on the old unit.

The old program was suspended when unit Y was relocated. After relocation, unit Y was thought of as a new unit. A new head nurse was hired, new staff were hired (some of whom moved from the old unit), a statement of unit philosophy and objectives (as previously listed) was developed, and special projects to be undertaken on unit Y were identified.

Among the special projects which the unit planned to undertake was the development and implementation of a nurse directed patient teaching program. The purpose of the teaching program was to:

1. Provide basic information to patients and their families regarding the specific disease condition.
2. Reinforce prescribed treatment to patients and their families.
3. Assist patients in effecting needed behaviors.
4. Provide support to patients and their families.

The proposal was submitted to the volunteer Association in November 1982. Approval for funding the program was confirmed in December 1982.

What happened as the process of change unfolded is described in Chapters 4 through 8 and covers the period from August 1982 to September 1984. Five somewhat distinct time periods of activity (which were later collapsed to four stages) emerged from the data and are presented in Table 3.1.

Program initiation/adoption occurred between August 1982 and January 1983. Planning for implementation was thought to have occurred between January 1983 and June 1983. The first program was implemented five times (A Trial Run) between June 1983 and November 1983. Planning and development for the revised program occurred during December 1983 and January 1984. The revised program as planned and developed was implemented and tracked in this study from January 1984 until data collection stopped in September 1984.

The stages of continuation/maintenance and outcomes did not evolve as distinct stages, however certain activities usually considered to be part of these stages did occur as the program was implemented.

The adoption/initiation stage of the program is described and discussed in Chapter 4.

Table 3.1

Activities by Time Periods in the Process of Change in the Present Study

| Activity | Time Periods |
|---|---|
| 1. Initiation/Adoption | August 1982 to January 1983 |
| 2. Planning for Implementation | January 1983 to June 1983 |
| 3. Implementation of the First Program (The Trial Run) | June 1983 to November 1983 |
| 4. Planning and Development | December 1983 to January 1984 |
| 5. Implementing the New Planned Program | January 1984 to September 1984 |

# CHAPTER 4

# PROGRAM INITIATION

## Introduction

The idea for the patient education program was conceived by the head nurse in the fall of 1981. A guarantee of funding for the program was received from the volunteer Association on December 15, 1982 and was followed by hospital approval to commence the program on January 18, 1983. Fullan (1982:39) labels this period in the change process as program initiation, mobilization, or adoption and describes it as "the process which leads up to and includes a decision to adopt or proceed with a change". The terms initiation and adoption are used interchangeably throughout the dissertation.

In this chapter an overview is provided of the events which occurred during Initiation followed by a discussion of the factors that emerged and appeared to have interacted and affected this stage of change. Three advance organizers are provided to guide the reader through the chapter. First, a list of events which occurred during Initiation is presented in Table 4.1. Second, the documents which were available on the unit about the initiation stage are listed in Table 4.2. Excerpts from the documents appear throughout the overview and discussion sections and are presented as evidence on which the findings were based. Each document excerpt is identified by a document reference number and an excerpt reference number. These numbers are presented as reference points throughout the discussion section of the chapter instead of repeating entire sections of

Table 4.1

Initiation Events

| Time-Line | Events |
|---|---|
| September 1981 | • Terms of reference for unit Y identified.<br>• Criteria for staff recruitment identified.<br>• Reporting structure for head nurse developed.<br>• Head nurse hired.<br>• Unit philosophy and objectives developed.<br>• Staff nurses recruited.<br>• Unit philosophy and objectives refined.<br>• Expectations for staff nurses refined. |
| April 1982 | • Unit Y opens in new location.<br>• Old program suspended.<br>• Committee structure developed.<br>• Need for new program identified.<br>• Available resources for program identified. |
| October 1982 | • Head nurse meets with volunteer Association.<br>• Head nurse collaborates with physio to develop request for funding. |
| November 1982 | • Request for funding submitted to volunteer Association. |
| December 1982 | • Volunteer Association approves request for funding. |
| January 1983 | • Director of nursing supports request for funding and seeks program approval from chief executive nursing officer. |

Table 4.2

Documentation About Program Initiation

| No. | Name | Date | Excerpt | Content |
|---|---|---|---|---|
| 1. | Terms of Reference for Unit Y | Sept. 1981 | #1 | • Director identifies unit Y as a place for change. |
| | | | #2 | • Director identifies characteristics required of unit Y head nurse (H.N.) |
| | | | #3 | • Director describes reporting structure for H.N. |
| | | | #4 | • Director identifies criteria for recruitment of staff nurses for unit Y. |
| 2. | Unit Y Yearly Report | Sept. 1983 | #1 | • Director describes fit between planned change on unit Y and philosophy of nursing at hospital X. |
| | | | #2 | • Director explains reason for choosing unit Y for implementation of planned change. |
| | | | #3 | • Director elaborates on characteristics of H.N. |
| | | | #4 | • Director identifies criteria for recruitment of staff nurses. |
| 3. | Head Nurse Planning and Development Document | After Sept. 1981 | #1 | • H.N. identifies need to recruit suitable staff. |
| 4. | Philosophy and Objectives of Unit Y | Spring 1982 | #1 | • H.N. describes process of recruitment of staff nurses. |
| | | | #2 | • H.N. describes functions of educational committee. |

Table 4.2 (continued)

| No. | Name | Date | Excerpt | Content |
|---|---|---|---|---|
| 5. | Concerns About The Old Education Program. Draft 2. | Spring 1982 | #1 | . H.N. discusses rationale for concern that staff nurses be involved in patient education program. |
| 6. | Proposal for Funding of Patient Education Program | Nov. 1982 | #1 | . H.N. identifies problems with old program. |
| | | | #2 | . H.N. explains reason for suspension of old program to president of volunteer Association. |
| | | | #3 | . H.N. identifies the goals, needs, and purpose of new program plus describes the program format and a plan for program commencement. |
| | | | #4 | . H.N. identifies future program development possibilities and need for additional funding. |
| 7. | Overview of Activities on [Unit Y] | Nov. 1982 | #1 | . H.N. identifies criteria for recruitment and selection of staff nurses. |
| 8. | Approval for Funding by Volunteer Association | Dec. 1982 | #1 | . President of volunteer Association approves funding of new program. |
| 9. | Memo from H.N. to Director | Jan. 1983 | #1 | . H.N. informs director of funding approval from volunteer Association. |
| 10. | Memo from Director to Chief Executive Nursing Officer. | Jan. 1983 | #1 | . Director informs CENO of funding approval and identifies actions required for implementation. |

document quotations. Finally, each document excerpt is preceded by a lead sentence, in which the main theme has been underlined to alert the reader to the context of the excerpt.

## Overview of the Initiation Stage

The events which occurred during Intitation are listed in Table 4.1. In 1981, plans were underway to move a unit for patients with a chronic illness from one location in hospital X to another location in the same hospital. A review of documents written by the director of nursing services revealed that unit Y was to be a place where planned change could occur. Among the objectives in the terms of reference for the new unit prepared by the director in September, 1981 was the following statement:

> . . . the unit will serve as a focus for the development and skills in leadership, administration and change agentry among nurses who demonstrate initiative and creativity (Document 1, Excerpt:1).

In a September, 1983 summary report about the unit, the director of nursing services referred to the way in which the implementation of planned change on unit Y was designed to fit into the philosophy of nursing at hospital X:

> It [the move into new physical surroundings] also presented an opportunity to implement certain planned changes or innovations which were consistent with the long range goals of nursing at [hospital X] (Document 2, Excerpt:1).

She went on later in the same report to explain:

> A number of management considerations precluded the possibility of implementing planned change on all the nursing units which were part of the initial occupancy. Therefore, one nursing unit, [unit Y], was selected to provide a focus for the development of a planned change strategy (Document 2, Excerpt:2).

In addition to describing unit Y as a place where planned change could occur, the director identified the characteristics required of the new leader, the head nurse, of unit Y:

> [Unit Y] will be administered by a H.N. with an appropriate professional background in clinical nursing, nursing administration and nursing education. A baccalaureate degree is required, but preference will be given to a nurse with preparation at the Masters' level because of the research focus and potential of the unit. The H.N. must be eligible for a joint appointment with the [Faculty of Nursing of a University] (Document 1, Excerpt:2).

She elaborated on the need for the leader to have the above characteristics:

> It was recognized that recruitment of an individual with these qualifications would be difficult, however, the decision to recruit a person with graduate level preparation and a comprehensive nursing background was reflective of recognition, at the senior levels of nursing management, of the complexity and importance of a [head nurse's] role. An assumption about the importance and potential impact of expert nursing leadership at the unit level was therefore implicit in this decision (Document 2, Excerpt:3).

The reporting structure for this new head nurse was described by the director:

> The H.N. will report to the director of nursing service. She will meet regularly with the area supervisors of medical units, for the purpose of co-ordinating activities on [unit Y] with those in other medical units (Document 1, Excerpt:3).

Most other head nurses in hospital X reported to their area supervisor.

The criteria for recruitment of staff nurses were also identified by the director:

> Recruitment and initial orientation of general duty personnel to the new facility will take place prior to opening date. An attempt will be made to recruit as many general duty nurses as possible with a baccalaureate degree (Document 1, Excerpt:4).

In addition, nurses would be recruited and retained "with high levels of motivation and skill within the department of medical nursing" (Document 2, Excerpt:4).

The head nurse was selected for unit Y in September of 1981 and she immediately produced a performance planning and development document identifying her goals and objectives among which was to "recruit suitable staff" (Document 3, Excerpt:1). The head nurse explained how she did this in a document which described the philosophy and objectives of unit Y:

> The staff of [unit Y] consist of carefully selected registered nurses who are committed to excellence in nursing practice and who engage in behaviour needed to maintain and share this excellence. Nurses are actively involved in all decisions related to patient care and accept accountability for these decisions (Document 4, Excerpt:1).

The criteria for recruitment and selection of staff were identified by the head nurse in an overview of the activities of unit Y in November, 1982:

> Recruitment and selection of staff was based on the following criteria:

> 1. Findings from the literature regarding the benefits of an all R.N. staff.
>
> 2. Agreement established with S.N.A. (Staff Nurses Association), regarding Level I and Level II nurses.
>
> 3. Concept and purpose of unit.
>
> There are 14 full time nursing positions allocated to [unit Y]. Twelve of these are currently filled with FTR [fulltime regular] staff (This was done in an attempt to make available the manpower needed to begin to perform some of the activities on [unit Y]). Ten of the 12 FTR nurses are Level II nurses and two are designated as Level I (The designation "Level II nurse" is an interim measure until the contract is settled. Other terms such as senior nurse or nurses leader will be considered) (Document 7, Excerpt:1).

Unit Y began functioning in April, 1982. Described among the functions of a newly formed educational committee of the unit was: "developing a patient teaching program in conjunction with physiotherapy and occupational therapy where appropriate" (Document 4, Excerpt:2).

The patient education program had been in place on the unit in the old location. This program was described as multidisciplinary in nature, including the services of physical therapy, social services, and nursing and had been developed and implemented primarily by the physiotherapists and occupational therapists. Implementation of the program had proceeded since 1980 but some problems had arisen.

Among the problems was an expressed concern by the staff nurses that they should become more involved in teaching the patients. Draft two of a paper by the head nurse in 1982 about the patient education program revealed this concern:

> All members of the health team, each from his specialized

> perspective, must be actively involved in the transmission of information to patients and their families. This includes nurses, who engage in patient care activities which not only overlap with the work of other team members, but also often extend and augment the efforts of the team. Nurses provide care around the clock and are therefore in the position to assess, evaluate and indeed monitor the effectiveness of the patient's total care. Consequently, nurses must be knowledgeable about and be closely involved in the patient education program (Document 5, Excerpt:1).

This concern was confirmed by the staff nurses, who had volunteered to teach the program, during a pilot group interview conducted on April 19, 1983:

> I: Why should nurses be involved in teaching the program?
>
> Ann: I would like to see the difference between the way patients respond before nurses took over and after. We recognize nursing as part of the program. The patients keep asking nurses the questions . . . like about lifestyle.
>
> Beth: We're seen as the ones who hand out meds. Pharmacy and physio were seen as the group who knew. The patients used them as resources. I only had to be asked [a question] by a patient once or twice. Then I knew how inadequate my knowledge was.
>
> Ruth: Patients saw that resources were O.T. and physio. Nurses are seen to bathe patients and get them ready for physio. I feel like a stewardess. Other units don't have a teaching mandate. I took this job because this was the mandate (Pilot Interview 1, Excerpt:1).

Additional problems with the old program were identified by the head nurse in the proposal she submitted to request funding from the volunteer Association:

> When [unit Y] moved to the [new facility] two problem areas were identified relating to the teaching program which was conducted at the time. These are outlined below.

> Amount of Patient Activity
>
> Rest is an essential part of the treatment of [the chronic illness]. However, given the number of trips which patients made to the main [building] for diagnostic tests, rehabilitation treatments, as well as for teaching sessions, there was little opportunity for patients to rest during the day time.
>
> Family Involvement
>
> Families generally visit during evening hours. However, because the education program was conducted during the day time, there was no opportunity for families to participate in the teaching-learning activities related to the program.
>
> After consultation among the members of the health care team, it was agreed that the identified problems could be alleviated if portions of the program were conducted in the evening.
>
> This alteration, however, results in what would be considered to be a new program and current hospital funding is unable to accommodate further new programs (Document 6, Excerpt:1).

The patient education program was subsequently suspended shortly after the physical move in 1982. The head nurse in the cover letter to a proposal requesting funding from the volunteer Association explained why and how the old education program was stopped:

> As you may know, the education program which was being conducted had to be stopped due to some of the problems identified in the attached document. As patient/family education is an important aspect of the total patient management, Dr. [Z], [the physiotherapist], and I hope that the Association will support this request (Document 6, Excerpt:2).

In October of 1982, the head nurse attended a meeting of the volunteer Association to voice her concerns about suspension of the patient education program and to test their receptivity to the idea of funding a new patient education program for the chronically ill patients on unit Y. On November 15, 1982, the head nurse in collaboration with the physiotherapist and the occupational therapist submitted a formal proposal for funding to the volunteer Association. Included in the proposal was a statement of the goals of the unit regarding patient care, a statement of the need for a new program, a list of problems with the old program (Document 6, Excerpt:1), a statement of the purpose of a new teaching program, and a brief description of the program format:

> [Unit Y] has been established to provide care to [patients with the chronic illness]. Included in the management of these patients is the provision of information by a multidisciplinary team regarding the specific disease condition.
>
> It has been suggested that the education of patients with [the chronic illness] and their families is central and fundamental to the management of the disease. Indeed, some experts in the area take the position that patient education, including families, is the single most important element in the management of [the chronic illness]. The assumption is that the more patients and their families know and understand the condition, the more likely they are to comply with the prescribed management regime.
>
> The intent of this document is to request funding from the [volunteer Association] to assist in the implementation of a patient education program on [unit Y]. Specifically, funding is requested for the proposed evening segments of the program.
>
> The purpose of the teaching program is to:
>
> 1. Provide basic information to patients and their families regarding the specific disease condition.
> 2. Reinforce prescribed treatment to patients and their families.
> 3. Assist patients in effecting needed behaviours.
> 4. Provide support to patients and their families.
>
> PROGRAM FORMAT AND CONTENT
>
> The program will be conducted over a two-week period. Physiotherapy and Nursing will be primarily responsible for

> conducting the evening sessions with Nursing teaching two 1 1/2 hour sessions per week and Physiotherapy presenting one 1 1/2 hour session per week (Document 6, Excerpt:3).

A condensed schedule of the program is presented in Figure 4.1. In addition, the proposal identified budgetary considerations in terms of required hours per week per year and required payment per hour per week per year for the nursing and physiotherapy participants. Alternatives for transfer of funds from the volunteer Association to hospital X were suggested and the most feasible alternative identified. The head nurse stated: "We will be developing a pamphlet which contains the program and would appreciate it if the Association would consider assuming the printing costs of the pamphlet" (Document 6, Excerpt:4). In the cover letter to the proposal, the head nurse indicated that the program could commence in January, 1983.

On December 15, 1982 the president of the volunteer Association replied to the request for funding:

> Further to your letter of November 15, 1982 requesting funding of the patient education program on [unit Y] at [hospital X]. The [volunteer Association] has decided to provide the funding needed for a period of one year. At the end of the one year period the Association would entertain a request for future yearly funding of this program.
>
> As to the method of payment, we ask that the Association be invoiced monthly, by the hospital. If this proves to be too awkward we would be open to changing the method of payment.
>
> We will also assume the cost of printing a pamphlet containing the program.
>
> We do hope that the evening sessions will become open to our members as there has been some interest shown in the program.

Week 1 and 2 Day Sessions

| Time | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| 0930-1015<br>1015-1100 | | | ← Physio → | | |

Evening Sessions Week 1

| | | | | | |
|---|---|---|---|---|---|
| 1930-2100 | | Film (on the unit) | Physio | Stress Management (on the unit) | |

Evening Sessions Week 2

| | | | | | |
|---|---|---|---|---|---|
| 1930-2100 | Community Resources (on the unit) | Physio | Pharmacy (on the unit) | Quackery (on the unit) | |

Figure 4.1

Planned Program Schedule

> We apologize for the lateness of this reply and wish you success with this program (Document 8, Excerpt:1).

The head nurse sent the following memo to the director of nursing services on January 4, 1983 informing her that funding for the program had been approved and outlining the rationale for the program:

> RE: Funding of Patient Education Program
>
> [Unit Y] was established to provide care to patients [with a chronic disease]. Included in the management of these patients is the provision of information regarding the specific disease condition.
>
> It has been suggested that the education of patients with [the chronic disease] is central and fundamental to the management of the disease. Indeed, some experts in the area take the position that the education of these patients and their families is the single most important element in the management of [the disease]. The assumption is that the more patients and their families know and understand the condition, the more likely they are to comply with the prescribed management regime. Historically, the [old] patient education program had been conducted by rehabilitation personnel only, and this group is to be congratulated for their initiative. They saw a need and developed a program to meet this need.
>
> When I took the position as H.N. of [unit Y], however, several areas related to the program caused me some concern. These are outlined below:
>
> 1. Rest is an essential part of the treatment of [the chronic disease]. However, given the number of trips which patients must make to the main hospital for diagnostic tests, individual rehabilitation treatments, as well as for the teaching sessions, there was no opportunity for patients to rest in the day time.
> 2. Family involvement in the teaching/learning activities of the program was minimal. Families generally visit in the evenings and the program was conducted totally during the day time hours.
> 3. The medical staff expressed concerns regarding the ability of the rehabilitation personnel to conduct the program as well as give individual patient treatments.

> 4. Patient teaching is espoused as being an integral part of nursing care and nurses were not involved in the education program.
>
> After consultation with all members of the health care team, it was agreed that the identified problems might be alleviated if portions of the program could be conducted in the evening. This modification, however, resulted in what might be considered a new program and hospital funding was unable to accommodate further new programs.
>
> I submitted a proposal to the [volunteer] Association seeking their support for implementing a new patient educational program. Specifically, funding was requested for the proposed evening segments of the program.
>
> You will be pleased to know that my proposal for funding was approved by the Association. The program is being funded for one year. An evaluation will then occur and it is hoped that the program can be expanded to include out-patients (Document 9, Excerpt:1).

In response, the director of nursing services sent the following memo to the chief executive nursing officer of hospital X with a copy to the head nurse on January 18, 1983:

> RE: Funding of Patient Education Program for Patients with [the chronic illness]
>
> Through involvement with the [volunteer] Association, [the H.N. of unit Y] has secured a commitment from the [Association] to fund a patient teaching program on the unit. The program was planned in consultation with the ward chief of the unit, and is a response to identified needs that could not be met within existing funding and work patterns.
>
> At this stage, I believe it is necessary to bring together representatives of the [volunteer Association], the Nursing Division, and the hospital Finance Department to formalize arrangements for the transfer of funds from the [volunteer Association] to the Hospital which will permit the program to commence.
>
> If you and [the finance representative] agree, I would suggest that a meeting be arranged to include myself, [the H.N.], the representatives of the [volunteer Association], and any other representatives you feel would be appropriate.

> Goals of the meeting would be to:
>
> 1. Provide recognition by senior hospital administration of the contribution the Association is prepared to make, and of the [H.N.'s] initiatives in working with the Association.
>
> 2. Secure a written commitment for funding from the Association from which the program can be systematically planned, implemented, and evaluated and to assure that there are no unforeseen or indirect costs to the hospital if the program is implemented. The Finance Department representatives at the meeting should be prepared to advise the Association representatives of the mechanisms by which funds are to be transferred to the hospital.
>
> 3. Target dates for transfer of funds and program implementation will be agreed upon.
>
> 4. Discussions with Association representatives regarding the public relations aspects of recognizing the Association contribution would be initiated.
>
> Our present and future concern with the cost containment will undoubtedly dictate the need to cultivate this and other relationships with voluntary organizations which could co-operate with the hospitals in the planning and funding of teaching programs. Therefore, establishing a formal mechanism within the organization for facilitating the receipt of donated program funds may be of increasing importance (Document 10, Excerpt:1).

Although no response to this memo was filed among unit documents, it was assumed in January of 1983 by the head nurse and the investigator that program initiation had been completed. The program had received funding and official hospital approval to proceed with implementation.

## Discussion of Program Initiation

Two observations, based on evidence presented in the preceding overview, were made by the investigator about the stage of initiation. First, two sets of factors emerged which appeared to have had an influence on the initiation of the change. The first set of factors appeared to have had a strong positive influence on initiation. It seemed that had these factors not been present, the program would in all likelihood not have been initiated. The second set of factors did not appear to have had as strong an influence on initiation as the first set; nevertheless, they did appear to have had a positive or supporting effect and did not appear to have impeded the initiation of the program.

The second observation had something to do with the nature of the change. Even during this very early stage, some impressions about the process of change began to emerge. The factors that influenced the stage of initiation and the impressions about the process of change that emerged during initiation are now discussed.

### Strong Positive Factors That Influenced Initiation

Seven factors emerged from the data and appear to have had a positive influence on the initiation of the program. These factors are presented in Table 4.3. Support of administration, support of the leader (the head nurse of unit Y), and availability of external funds emerged as the three factors having the strongest positive influence on the program initiation.

Support of administration. Actions taken by senior nursing administration, specifically the director of nursing services, indicated that administration supported the change. The director of nursing made it clear in her planning documents that she, speaking on

Table 4.3

Factors Influencing the Initiation Stage

| Factors |
|---|
| 1. Strong Positive Influence |
| 1.1 Support of Administration |
| 1.2 Support of the Leader |
| 1.3 Availability of External Funds |
| 2. Positive/Supporting Influences |
| 2.1 Support of the Staff |
| 2.2 Support of the Community |
| 2.3 Support of Other Organizational Departments and Personnel |
| 2.4 Identification of Expected Outcomes |

behalf of senior nursing administration supported the idea of change/ innovation in hospital X and specifically on unit Y (Document 1, Excerpt:1; and Document 2, Excerpt:2). From her point of view the change fitted with the overall philosophy and objectives of the hospital and the division of nursing (Document 2, Excerpt:1). The director relayed her support of the program to the chief executive nursing officer (Document 10, Excerpt:1) and in addition, suggested that this kind of relationship with external funding agencies should be cultivated. Because no statements of disapproval were issued by the chief executive nursing officer, it appeared that program initiation was supported by all levels of senior nursing administration at hospital X.

In addition to supporting the change, the director identified two elements which she deemed were essential for successful implementation of the change. The first element identified was the set of criteria for selection of the head nurse and staff nurses on unit Y (Document 1, Excerpt:2 and 4). According to the director, the head nurse should have an appropriate professional background in clinical nursing, administration and education and should preferably be prepared at the master's level (Document 1, Excerpt:2 and Document 2, Excerpt:3). The staff nurses should be motivated, skilled and preferably be prepared at the baccalaureate level (Document 1, Excerpt:4 and Document 2, Excerpt:4). The second element deemed necessary for successful implementation was a reporting structure which allowed the head nurse direct access to the director (Document 1, Excerpt:3). The head nurse would report to the director rather than to the area supervisor, who was one level lower, the normal reporting procedure in hospital X.

In addition to supporting the change and identifying essential elements for success, the director suggested two actions which senior nursing administration should take to operationalize the change (Document 10, Excerpt:1). First, senior nursing administration should communicate recognition of the efforts to mount the program to the volunteer Association and the head nurse. Second, a formal mechanism should be established within the hospital to handle the transfer of funds from the volunteer Association to hospital X.

As evidenced, senior nursing adminstration, specifically the director of nursing services, supported change on unit Y. This support appears to have had a positive influence on the initiation of the patient education program and is congruent with Fullan's (1982:45) explanation about the adoption of change in the education setting: ". . . adoption never occurs without an advocate, and one of the most powerful is the chief district administrator, with his or her staff."

Support of the leader (head nurse of unit Y). Actions taken by the head nurse indicated that she supported the mandate of planned change on unit Y and in fact instigated the adoption of the program. She supported the objective of the director to recruit movitated skilled staff who had baccalaureate degrees (Document 3, Excerpt:1 and Document 4, Excerpt:1) and identified the criteria used to recruit and select the staff. The staff who were selected consisted of all registered nurses, most at the senior nursing level, who complemented the concept and purpose of the unit (Document 7, Excerpt:1). The head nurse proceeded to establish a committee structure which allowed unit objectives to be operationalized. An education committee was formed, one of its mandates being to implement the patient teaching program (Document 4, Excerpt:2). It was the head nurse who documented the need for nurses to be involved in the program (Document 5, Excerpt:1) and it was she who went on to identify problems with the old program (Document 6, Excerpt:1). The head nurse was instrumental in stopping the old program (Document 6, Excerpt:2). Finally, it was the head nurse who obtained funding for the new program (Document 6, Excerpt:3; Document 8, Excerpt:1; and Document 9, Excerpt:1).

It has long been recognized in the literature that change has a much better probability of being adopted and effectively implemented when leaders at the work technology level, in this case unit Y, are involved in planning at an early stage. Rogers (1972) discussed the advantages of gaining the support of the leaders of agricultural communities, where change was being proposed, early in the process. In this study the leader of the agricultural community would be the head nurse of unit Y. Evidence has been presented to indicate that she supported the change and was instrumental in the adoption of the program.

Availability of external funds. Actions taken by both the director and head nurse revealed that they recognized the need to solicit external funds in order to approve adoption of the program and to proceed with implementation. The head nurse had determined that the program would have to be taught in the evenings, thus requiring replacement staff to be hired, or present staff to be paid overtime. In any case extra funds would be required to teach the new program.

She also was aware of the fact that current funding conditions at the hospital could not accommodate further new programs (Document 6, Excerpt:1 and Document 9, Excerpt:1).

The head nurse was convinced of the need for the program (Document 6, Excerpt:3) and had confirmed the need with her staff, the department of physiotherapy, and the doctors (Document 9, Excerpt:1). In addition she had discussed her concerns about the old program with the volunteer Association in October, 1982 and had concluded that the volunteer Association also recognized the need for and potential benefits of the program. Therefore, relying on previous amicable relations, the head nurse requested funding from the volunteer Association (Document 6, Excerpt:3). Funding was requested for payment of nursing salaries to teach the program in the evenings. No funding was requested for planning time. The director supported the request of the head nurse for external funding and reiterated the fact that the program could not be mounted given the existing funds available and the current concern with cost containment that existed at hospital X (Document 10, Excerpt:1).

The evidence seems to strongly indicate that it was the guarantee of external funding which assured program adoption. The finding that the availability of external funds had a positive influence on initiation of the change is supported by Fullan (1982:49) who reported that ". . . the availability of resources external to the district is a powerful stimulant for adoption."

### Positive Supporting Factors That Influenced Initiation

Support of the staff, support of the community, support of other departments and personnel, and the ability to identify expected outcomes emerged as factors which also had a positive, though not as strong an influence on initiation.

Support of the staff. Although no systematic data were collected from the staff nurses during the adoption stage (the investigator had not yet received official approval to conduct the study) and the staff nurses as a rule do not generate documents (as did the director and the head nurse), there is nevertheless embedded in the documents which were available some evidence to indicate that the staff did support the adoption of the program. The staff nurses had been selected to complement the concept and purpose of the unit (Document 7, Excerpt:1). They confirmed in excerpts from the April, 1983 pilot interview that they had joined the unit because of its innovative mandate. The head nurse seemed to be voicing both her own and the staff nurses concerns when she documented (only in draft form) that the nurses must be knowledgable about and closely involved in the patient education program (Document 5, Excerpt:1). To emphasize her point the head nurse pointed out to the director, in an official document, that patient teaching was an integral part of nursing care and that the nurses had not been involved in the old program (Document 9, Excerpt:1). Some of the staff nurses had volunteered to be on the education committee and one of the functions of the education committee was to plan and implement the patient teaching program (Document 4, Excerpt:2). In addition, while the investigator was not systemically collecting data during the adoption stage, she was occasionally on the unit conducting the evaluability assessment (Rutman:1977). It was during these assessment visits that the investigator sensed the support of the staff nurses for adoption of the program. Four of the 14 nurses confided that they were interested in actively teaching in the program when it was adopted while the remainder of the nurses displayed a range of support from neutral to uninvolved enthusiasm. However, it seemed that none of the staff nurses opposed adoption of the program. The investigator also learned at this time that two of the staff nurses had attended meetings of the volunteer Association.

It therefore seemed reasonable to conclude that the staff nurses as a group supported adoption of the change. It also seemed reasonable to assume that this show of support and some commitment on the part of the staff nurses toward future implementation of the program was recognized by the director and the volunteer Association and positively affected the decision to approve funding and implementation of the program.

These findings are congruent with the work of Rogers (1972) on change and the role of change agents in agricultural communities. Rogers found that, in addition to having the support of the leaders to ensure successful implementation, it was wise to have some indication of the degree of support and commitment of the other farmers, in this study the staff nurses, before approving adoption of the change. In the recent literature, Fullan (1982:46) concurs with this notion of gauging and seeking support of the staff and suggests that when staff (teachers) have access to innovations, their interaction can be a powerful source of influence on adoption and especially on its use.

Support of the community. The community referred to during the initiation stage of the change were the members of the volunteer Association. All of the members, perhaps excluding some paid staff, were themselves former and current patients who lived daily with the chronic illness. Implicit in the evidence presented was the assumption that they supported adoption of the program. It appears that the Association members agreed with the head nurse in the October, 1982 meeting that the program was needed. The Association quickly replied to the proposal for funding with a guarantee of funds for one year (Document 8, Excerpt:1). In addition they requested that the program be evaluated, that when the program was stabilized members of the volunteer Association be allowed to attend, and indicated that future funds might be forthcoming.

According to Fullan (1982:47) ". . . communities can instigate educational change." While this community of former patients did not instigate the change, there is evidence to indicate that they actively supported adoption of the change.

Support of other organizational departments and personnel.. Embedded in the documents was an indication that other departments and personnel in liaison with unit Y were supportive of adopting the program. The old program had been developed and implemented by the rehabilitation department, specifically one physiotherapist (Document 9, Excerpt:1). This physiotherapist indicated her willingness to keep the head nurse of unit Y informed about the old program. Sometime early in 1982 (the date of receipt was not noted) the physiotherapist sent the head nurse a copy of the old program entitled "An Interdisciplinary Educational Program For Patients With [the chronic illness]: A Guide for Professional Staff, Revised 1981." As previously indicated, problems developed with the old program when unit Y was moved into a new location (Document 6, Excerpt:1). Because of these problems the decision was made to suspend the program (Document 6, Excerpt:2). The head nurse explained that after consultation among the members of the health care team, specifically the ward chief, the physiotherapist and herself, the decision had been reached to try to develop and conduct a new program (Document 6, Excerpt:1 and 2 and Document 9, Excerpt:1). It appears that the decision was a collaborative one and therefore had the support of the physiotherapist and the doctors on the unit. This indication of support from the physiotherapist and particularly the doctors seems to have had a favourable impact on both the director and the funding agency and ultimately was a positive influence for initiation of the program.

Identification of expected outcomes. Although the evidence is not particularly strong, it appears that the participants in the change could identify very early in the change process what some expected outcomes of implementation of the program might be. These expected outcomes in fact seemed to be the basis on which the need for the program was grounded. For instance, the head nurse and staff nurses were interested in comparing the patient behaviours before the program was taught by nurses and after the program was taught by nurses (Pilot

Interview Excerpt), specifically patient compliance with a prescribed management regimen (Document 6, Excerpt:3). The head nurse and staff nurses also felt that patient teaching should be an integral part of nursing care and that the staff nurses should be involved in the program (Document 5, Excerpt:1 and Document 9, Excerpt:1). In addition the staff nurses seemed to feel that the ability to successfully teach in the program would raise their self-esteem both in their own eyes and the eyes of the patients (Pilot Interview 1, Excerpt:1). The director saw that in addition to meeting the objectives for which the unit was established (Document 1, Excerpt:2), successful adoption and implementation of the program could produce an added benefit in the form of an established system or mechanism whereby similar external funds could be solicited for other patient education programs in the hospital (Document 10, Excerpt:1). The volunteer Association expected that after a stabilization period, members of the Association could take part in the teaching program (Document 8, Excerpt:1).

While the identification of these expected outcomes by the participants during the adoption stage did not appear to have had a profound influence on the adoption itself, one can argue that had these participants not been able to identify some expected 'return on investment' they would not have supported adoption of the program.

## Impressions About the Change Process

Two impressions about the process of change began to emerge ever so faintly during the adoption stage. These impressions had something to do with the kind of relationships that would develop among the participants during the change process and the amount of time that was allowed for planning for implementation. The investigator began to question (1) whether the change process would be one of collaborative effort or one involving conflict over program ownership? and (2) would planning for implementation occur?

Collaboration vs. conflict. Evidence in the documents indicated that the adoption of the change was a collaborative effort. Members of the health team had recognized the need for a new program, had agreed to suspend the old program, and had supported the proposal that funding be sought to mount the new program (Document 5, Excerpt:1; Document 6, Excerpt:2 and Document 9, Excerpt:1). However, embedded in the documents was some evidence that dissent could be looming on the horizon.

Personnel from the rehabilitation department had been primarily, if not solely, responsible for planning and conducting the old program (Document 9, Excerpt:1). In contrast to the previous situation, the head nurse now viewed the proposed program as a new one with the staff nurses playing a larger role in implementation then had been the case with the old program (Document 5, Excerpt:1; Document 6, Excerpt:3; and Document 9, Excerpt:1). One planning document (in draft form only) prepared by the head nurse in the fall of 1982 put forth a recommendation that "nursing be responsible for coordinating and implementing the program." This recommendation did not appear in the final proposal for funding which suggested that the program be a joint venture among physiotherapy, occupational therapy and nursing with nursing teaching a larger proportion of the funded sessions (Document 6, Excerpt:3). As evidenced in the pilot interview excerpt with the staff nurses, they thought they were to be in control of and would "take over" the program.

Planning for implementation. The head nurse had proposed in November, 1982 that upon receipt of funding, the program would commence in January, 1983 (Document 6, Excerpt:3). While the documents indicated that resource needs for implementation had been identified (Document 6, Excerpt:3) there was no indication that time needs for the staff nurses to plan for implementation had been identified during the adoption period. The investigator began to question whether the time from receipt of funding approval (December 1982) to projected implementation, January 1983, was too short to allow the nurses to plan for implementation. Fullan (1982) identified this problem when he discussed the time-line from awareness to adoption and from adoption to start-up of implementation. He (Fullan, 1982:53) warned:

> Thus, once the decision is made, things happen quickly--too quickly in the sense that the short time-line provides little opportunity for planning for implementation. Or, more precisely, planning for implementation is not recognized as an important component requiring more advance attention.

The time-line in the present study from awareness to adoption was about 16 months while the proposed time-line from adoption to start-up was to be one month.

## Summary of the Initiation Stage

In the fall of 1981 a new unit, which in this study has been called unit Y, of hospital X, was identified by the director of nursing services as a setting in which planned change and innovation could occur. A head nurse for unit Y was recruited according to pre-determined criteria, and she in turn selected the staff nurses for unit Y. The philosophy and objectives of the unit were developed and steps were taken to initiate one of the objectives, that being to develop and implement a patient education program for patients with a chronic illness. A proposal for funding of the program was developed by the head nurse in collaboration with one other department, rehabilitation, and the ward chief of the unit and was submitted to a volunteer Association in November, 1982. The Association responded favourably and approved funding for the program in December, 1982.

Analyses of the data revealed that seven factors appeared to have influenced the decision to initiate or adopt the program. In addition, two impressions about the process of change began to emerge during the stage of initiation.

Of the seven factors, three appeared to have had a strong positive influence on the decision to adopt the change. The three factors were support of administration, support of the unit leader, and availability of external funds. The remaining four factors, while not having as strong an influence on the decision to adopt, still appeared to have had a positive supporting influence on the adoption stage. These factors were support of the staff, support of the community, support of other departments and personnel, and the ability to identify expected outcomes. Fullan (1982:42) reviewed the literature and identified what he saw as the main factors which affected adoption. A comparison of the factors generated in the present study and those generated by Fullan is presented in Table 4.4. Four of the factors generated in this study were also identified by Fullan to have an influence on the stage of adoption. Those factors where support of administration, availability of funds, support of the staff, and support of the community.

Finally, at this early stage in the change process, two impressions about the change process began to emerge. The investigator began to be sensitive to: (1) the direction the change might take in terms of the kinds of relationships that could develop between the participants during the process and (2) the kind of planning for implementation which might occur. The investigator was left with some questions or hypotheses about what might happen after the adoption stage. It seemed that one could begin to sense whether the change was bound to succeed or doomed to fail. Fullan (1982:53) expressed these similar sentiments much more succinctly:

> The nature of the adoption process and of its interface with implementation warrants more attention by researchers and planners of change, because of its impact on the outcomes of attempted educational change. It is during the adoption phase that the direction or content of change is set in motion. Decisions are made about what is to change, at least in terms of goals and sometimes substance. The process of adoption can generate meaning or confusion, commitment or alienation, or simply ignorance on the part of participants and others to be affected by the change.

Table 4.4

A Comparison of Factors Associated With Adoption
Identified in the Present Study with those
Identified by Fullan

| Factors Generated in the Present Study | Factors Generated by Fullan: 1982 |
|---|---|
| Strong Positive Influence | |
| *1. Support of administration. | 1. Existence and quality of innovations. |
| 2. Support of unit leader. | 2. Access to information. |
| *3. Availability of external funds. | 3. Advocacy from central administrators. |
| | 4. Teacher pressure/support. |
| Positive/Supporting Influence | 5. Consultants and change agents. |
| *4. Support of staff. | 6. Community pressure/support/apathy/opposition. |
| *5. Support of community. | 7. Availability of federal or other funds. |
| 6. Support of other departments. | 8. New central legislation or policy (federal/state/provincial). |
| 7. Identification of expected outcomes. | 9. Problem-solving incentives for adoption. |
| | 10. Bureaucratic incentives for adoption. |

* Factors identified in present study which were also identified by Fullan to influence adoption.

The stage of Planning for Implementation is discussed in the next chapter.

# CHAPTER 5

# PROGRAM IMPLEMENTATION: PLANNING FOR IMPLEMENTATION

## Introduction

Fullan (1982:54) defines implementation as " . . . the process of putting into practice an idea, program, or set of activities new to the people attempting or expected to change." The process of implementation, in this study, moved through four stages: planning for implementation, implementing the trial run, planning and development, and implementing the planned programs. This chapter focuses on Planning for Implementation and is comprised of three main sections. In the first section, an overview is provided of the events which occurred during Planning for Implementation. The factors that appeared to have interacted with and affected the process are identified and discussed in the second section. Finally, a summary of the stage of Planning for Implementation is provided.

## Overview of Planning for Implementation

The events which occurred during this stage are listed in Table 5.1. Although the program was adopted in December of 1982 and it was indicated in the proposal that implementation could commence in January of 1983, the nurses in fact did not begin to teach the first program until June 14, 1983.

An economic recession in the early 1980's had an impact on the provincial government funding of the hospitals. In early 1983, the Provincial Minister of Hospitals informed hospital boards that the

Table 5.1

Implementation: Planning for Implementation

| Time - Line 1983 | Events |
|---|---|
| January | . Program implementation delayed.<br>. Four teaching nurses volunteer to teach the program. |
| April 5 | . Administration gives approval to implement the program.<br>. Training session conducted for teaching nurses. |
| April 19 | . First meeting between teaching nurses and investigator. |
| May 6 | . Second meeting between teaching nurses and investigator.<br>. Head nurse develops objectives for one teaching session. |
| June 3 | . Third meeting between teaching nurses and investigator. |

previous departmental policy of deficit funding would be discontinued. While this decision did not affect funding of the patient education program (external funding had been guaranteed), it did affect implementation of the program. The effect was two fold. First, nurses in the hospital, particularly those working part-time and those most recently hired, were faced with the possibility of losing their jobs. Three of the nurses on unit Y who expressed an interest in teaching the program were affected in this way. Second, many operational changes were necessary on the nursing units as nurses subjected routine practices to scrutiny in order to deliver care with fewer staff. Any nursing activity which could be perceived as an "add on" (e.g., the teaching program) was approached cautiously. Nursing administrators were concerned about workload and morale of staff nurses and were aware that both clinical and administrative nursing practices were being examined by senior management. A decision was made by the head nurse and the director of nursing services to delay implementation of the teaching program.

The staff continued to express commitment to the program and the four staff nurses (Beth, Ann, Ruth, and Marg) who originally expressed an interest in teaching the program volunteered to become the teaching nurses. However, between January and mid-April, 1983, the four nurses did not meet as a group to plan for implementation of the teaching program.

On April 5, 1983, the head nurse of unit Y and the director decided to proceed with implementation. A training session for the four teaching nurses was planned by the head nurse in collaboration with the department of physiotherapy. The physiotherapist selected four patients to whom the old program could be taught. The teaching nurses were to attend those sessions and observe. The training program was conducted in mid April. All of the teaching nurses managed to attend at least one of the training sessions; however, no teaching nurse attended all of the sessions.

The teaching nurses made the following statements about not attending the sessions:

> Ruth: Lots of times we weren't working that day.
> Beth: I was working and couldn't leave the floor.
> Ann: I think it is very difficult to get away from the floor to attend the sessions (Pilot Interview 1, Excerpt:2).

On April 19, the final day of the training session, the investigator requested permission from the head nurse to interview the teaching nurses. This was the first time that Beth, Ann, and Ruth met to discuss the teaching program. The head nurse was not present. Seventeen days later, the investigator again interviewed the same nurses. The head nurse requested permission to attend this interview. One month later, the investigator conducted the third group interview. Two of the teaching nurses (Ruth and Marg) and the head nurse attended. The nurses met once between the second and third interviews to discuss the program. It was during these three meetings that the nurses planned for implementation and that concerns of the teaching nurses about implementation, characteristics of the change, and some of the expected outcomes of the change began to emerge. These concerns are reported below. Throughout some of the excerpts included in this section, it appears that the nurses were teaching the classes. This was not the case. The nurses were reporting on their observations of the training sessions and implementation of the old program.

## Concerns Identified During the First Meeting

The concerns raised by the nurses during the first meeting are listed in Table 5.2. The concerns focussed on five areas: the mechanics of implementation, the needs of the learners, the content to be taught, the program development and delivery needs, and the needs of the nurses.

Mechanics of implementation. The teaching nurses were concerned about how difficult it would be to implement the program and how much preparation they would be required to do on their own:

> Beth: How hard will it be to implement the program? Will it be in our own time, on days off, will extra staff be required (Pilot Interview 1, Excerpt:3)?

Needs of the learners. The nurses felt that the learners should be taught in terms that they could understand and that the learners should be presented with accurate information about their illness. However, the nurses were not sure how to identify what the learners needed to know:

> Ann: O.T. and physio had talked above their [the patient's] heads.
> Ruth: I'm concerned about the patients getting the wrong ideas about their disease.
> Ann: How are we going to find out what the patients need (Pilot Interview , Excerpt:4)?

Table 5.2

Areas of Concern Identified by Teaching Nurses in the First Meeting

| Concerns of Teaching Nurses |
|---|
| 1. Mechanics of implementation. |
| 2. Needs of the learners. |
| 3. Program content. |
| 4. Program development and delivery. |
| 5. Needs of the nurses. |

Content. The nurses mentioned the need to spend some time on content development:

> Ann: We're not working on the content.
> Beth: The content has been developed by others.
> Ruth: We're just jumping into their bag.
> Beth: We'll have to develop lectures with general ideas . . . like coping (Pilot Interview 1, Excerpt:5).

Program needs. The nurses began to identify program development and delivery needs beyond those that had been included in the old program, particularly in the area of assessment and evaluation:

> Beth: We need a way to develop an objective questionnaire for before and after they take the program.
> Ruth: It should be a real evaluation. They wouldn't have to sign it; it would be confidential.
> Ann: We should get the opinions of this group going on Friday.
> Ruth: It would be interesting to watch this group [of patients] when they come back [to the unit] (Pilot Interview 1, Excerpt:6).

Needs of the nurses. The nurses talked about some of their own fears, frustrations and needs. They were frustrated by the delay in program start-up. One nurse had lost her enthusiasm. They were concerned about not having any teaching experience:

> Beth: It's been so long getting it [the program] going. I don't feel much like doing it any more. I'm not as enthused.
> Ruth: We have no teaching experience (Pilot Interview 1, Excerpt:7).

## Concerns Identified During the Second Meeting

The concerns raised by the nurses during the second meeting are listed in Table 5.3. These concerns focussed on three areas: the

Table 5.3

Concerns Identified by Teaching Nurses
During the Second Meeting

1. Concerns about program development and delivery
    - 1.1 assessment tools
    - 1.2 content
    - 1.3 standardization
    - 1.4 scheduling
    - 1.5 coordination with other departments

2. Concerns about the learners
    - 2.1 involvement in own learning
    - 2.2 need for reinforcement
    - 2.3 need to include family members

3. Concerns about own needs
    - 3.1 need for planning time
    - 3.2 kind of teaching methods required
    - 3.3 need to be seen as credible
    - 3.4 need to involve other staff nurses
    - 3.5 need to know about history of adoption
    - 3.6 impact of program on own time

4. Characteristics of the change
    - 4.1 pacing of the change

5. Learner outcomes

program itself, the learners, and the teaching nurses. In addition to concerns about implementation, one characteristic of the change and some observed learner outcomes of the change began to emerge.

Concerns about program development and delivery. These concerns cut across five areas and overlapped. The nurses mentioned assessment tools, content, scheduling, standardization, and coordination with other departments.

Ruth identified the need to develop an assessment tool:

> Well, we were just talking - it wasn't so much the teaching program (the teaching program probably in the end) but we were talking about our new admission/history sheet and for them [the patients] to do an assessment before they came in, of their problems (Pilot Interview 2, Excerpt:1).

The nurses were concerned about the content of the program. What was to be taught in the program? What had been taught in the old program? What new learning would be required in order to teach in the program?

> Beth: I was talking to the head nurse earlier today and I told her that I might have problems, for instance with the quackery one. It's a good session but I don't agree with everything they [physio and O.T.] tell the patients. This is my own personal belief. And I thought "How am I going to stand up and tell people about something that I don't believe." I know I should be able to but it bothers me. I know I'm still going to have to learn more (Pilot Interview 2, Excerpt:2).

The nurses questioned whether the content and presentation should be standardized:

> Ann: I'd like to see some modules that are standardized. I would prepare quite a lot if I was asked to do one session say next week. I would really get busy and research and get it all together, and I would probably check with the head nurse and the staff before I presented it because I think that it should be standardized (Pilot Interview 2, Excerpt:3).

In response, the head nurse suggested that the objectives could be standardized:

> Head Nurse: I've got all the material that they [physio] used, but I think that we have to develop each session for our own use. We just listened to them to see the kind of information that they presented. I don't expect that we are going to follow that word for word, because we've all had teaching and/or experience from school and we know there are certain things that should be presented in a certain way. I think that one of the first things we have to do now is develop the objectives. The modules, I think, will take a while to develop. Certain standard information is there, but you will adopt it and present it in your own way (Pilot Interview 2, Excerpt:4).

The teaching nurse was not satisfied with this explanation. Remember, all the teaching nurses had not attended all the training sessions, and none of the teaching nurses had seen the training material:

> Ann: Based on an outline?
> Head Nurse: Everybody is an individual and with their own individual way of teaching it (Pilot Interview 2, Excerpt:5).

The teaching nurse explained the rationale for standardization:

> Ann: It would be a shame not to cover the same points. One group [of patients] might miss certain points.
> Head Nurse: That's why you do have to sort of have basic information in all of the sessions, but each person can present it in a way that they can feel comfortable doing it (Pilot Interview 2, Excerpt:6).

Later in the same meeting the nurses decided to meet the following Monday to develop the objectives. In addition, they tried to gain further clarification about the content of this program:

> Head Nurse: And you can be thinking about it [the meeting] in the back of your head all weekend.
> Ann: Which one are we going to work on first? Are we going to work on the one about stress?
> Ruth: We should get some books to study.
> Ann: Are we going to work on the objectives?
> Beth: Yes, because we have most of the basics. Is there any way that we can prepare more than just the objectives?
> Ann: You mean objectives for the one where we show the film? We have sort of an introduction?
> Head Nurse: Well, at the moment I would say let's leave the structure of the first session [the film] and concentrate on the other two that do require a bit more.
> Ann: Yes.
> Ruth: My understanding of the film is that it is the introduction. It gives them some of the information they may need while they are here and prepares them to go home.
> Head Nurse: I have all the material that they [physio] used to give before.
> Ann: Could a copy of that be made for each of us? Would that be too much?
> Head Nurse: Well, why don't I just copy these two sessions? I could do that.
> Ann: It would be nice if we each had a copy.
> Head Nurse: O.K. Then we could go home and do a little bit of work on it. There'll be other things that you will want to add.
> Beth: And we don't have much time.
> Ruth: Yes, for reading it.
> Ann: We could come prepared.
> Head Nurse: I'll do that before I go today (Pilot Interview 2, Excerpt:5).

More specific concerns about scheduling of the program were raised by the nurses during this second meeting. Imbedded in the scheduling concerns were concerns about content:

> Beth: I asked [the head nurse] how it was going to work if we were either working on the unit or were on days off and we each always taught the same one. She said it would be

> harder, with so few of us to cover people on vacation and days off if somebody is away. How are we going to teach that particular session?
> Head Nurse: I wonder Darlene, if I could talk a little bit about structuring the program and what each of us feel we would like to do? I still feel [Beth], that it wouldn't be logical to have each of you know only one session because of the logistics of presenting the sessions. So to give each of us the most flexibility, I think that you will have to . . . there are really only three sessions that we are presenting anyway. So, how would you feel about being prepared in all three?
> Beth: It will take a bit longer, I suppose.
> Ruth: I think it will be helpful and we will learn a lot that way. There will be some research to do but a lot of it will come very naturally as we work on our own outlines and objectives (Pilot Interview 2, Excerpt:8).

In addition to concerns about scheduling the nurses to teach the program, concerns also emerged about scheduling the patients and their families to receive the program, coordinating with the physiotherapy department and infringing on the personal lives of the nurses:

> Ruth: We have a lot of people who live a long way from town. It isn't feasible for families to come. And a lot of them are not from the urban areas, they are from rural areas and there is work to be done at home - family - you know.
> Beth: We have a problem scheduling some of these ones from out of town. Sometimes a family comes here for a weekend. Did we have any plans for scheduling other than what we did the last time?
> Head Nurse: I didn't, but it is something to think about, if we are willing to come in on the weekends ourselves and do it.
> Beth: Well, I'm not saying. Personally, I like days off for myself.
> Ruth: I thought that maybe the film should be given on a Friday night or a Sunday evening when they come back with their families, so the family can sit in on that first one.
> Head Nurse: I think that is an excellent thought. I see no reason why we can't. We have the film and we just have to make sure that we arrange for a video.
> Beth: Because for each particular two week session, we can sit down and discuss it with the patients ahead of time, and then plan what day. It could be different every two weeks.
> Head Nurse: Oh sure, it could be. As long as we don't interfere with those evenings that the other people [physio]

> are giving theirs.
> Ruth: Because they don't have anything either Friday or Sunday night.
> Head Nurse: No, but we want to be careful of a Friday night, that people aren't out on pass.
> Ruth: No but, that's a condition, that they can't go out.
> Ann: I would say that Sunday night would be a better time.
> Ruth: They have to come back anyway.
> Beth: It will always depend if there is anybody from out of town (Pilot Interview 2, Excerpt:9).

While discussing when the first program would be taught, the nurses identified a need to coordinate with other hospital departments, particularly the physiotherapy department and the out-patients clinic:

> I: When does the first program start?
> Head Nurse: We're not sure. [Physio] and I decided that we need at least four patients to make it worthwhile. We wouldn't run a program with less than that. At the beginning of every week we have to look and see who we have on the ward and see if they're suitable.
> I: At this point you are not sure how much lead time you have until the next set of patients come in?
> Head Nurse: It could be a week.
> Ann: We don't get any out-patients from the doctors' offices?
> Head Nurse: Well, it's possible that we can use out-patients if physio knows of some patients that are coming in through the clinic.
> Ann: That's why one of our nurses should be working in the clinic. But we don't really have any liaison.
> Head Nurse: Not yet we don't, but I think these are the kinds of things that we can be thinking about and suggesting in the future (Pilot Interview 2, Excerpt:10).

Concerns about the learners. The second major area of concern focussed on the learners. The teaching nurses thought the learners should be involved in their own learning:

> Beth: Having them [the patients] do an assessment is another part of their teaching. It's a way to get them more involved (Pilot Interview 2, Excerpt:11).

The nurses recognized that the learners would need reinforcement of the teaching:

> Ann: I'd like to see the modules standardized, then if we wanted to refer to the information between teaching sessions, it would be available on the ward to look up and discuss it with the individual patient (Pilot Interview 2, Excerpt:12).

The nurses considered family members to also be learners:

> Ann: It is really important that we get families into it. I've had so many patients that I can recall where the husbands just don't understand.
> Head Nurse: We must get families into the program. That is one of the reasons for putting these sessions on at night (Pilot Interview 2, Excerpt:13).

Concerns about the teaching nurses own needs. The needs of the teaching nurse cut across six areas: need for planning time, need for knowledge about teaching methods, need to be seen as credible, need to involve staff nurses, need for knowledge about the history of adoption, and need for clarification of expectations about the amount of personal involvement that would be required in the program.

The head nurse when trying to decide how to develop the objectives began to identify the need for planning time:

> Head Nurse: Some of you would be coming in on your time off just to plan. We need to get together as a group for planning and study for a couple of hours. Do you think that sounds good? Are there any suggestions?
> [No suggestions].
> Head Nurse: Well, why don't you consider it?
> Ann: I don't know whether it's possible or not to work on only one session (Pilot Interview 2, Excerpt:14).

Later in the meeting while discussing how to schedule the sessions to meet the needs of the rural learners, the head nurse again refers to planning:

> Head Nurse: Maybe what we are going to have to do then is when we know we're going to be running a program, we should sit down quickly for about fifteen minutes and decide what we're going to do, what schedule to work (Pilot Interview 2, Excerpt:15).

At the end of the meeting, the teaching nurses refer to the need for planning time in response to a question from the investigator:

> I: I'm interested in your reaction to this kind of a meeting.
> Ann: Actually, I think that you coming, and gathering us together, makes us sit down and discuss this program.
> Beth: It's the only way we get together.
> Ruth: I think if nothing else, it makes us think (Pilot Interview 2, Excerpt:16).

A second concern focussed on the kinds of teaching methods required to teach in a group setting as opposed to teaching on a one-to-one basis which the nurses had been doing:

> Beth: The patients sort of lead up to whatever they are most interested in. You follow whatever it is they want to know and some of them know more than others. The sessions are informal and that is nice for the patients (Pilot Interview 2, Excerpt:17).

However, later in the meeting, Beth begins to have some reservations:

> Beth: How are we going to give ourselves an opportunity to practice? Practice giving a session and working on techniques like small group dynamics and speaking.
> Head Nurse: Well, we could do two things. We could do it to the group and we could also put ourselves on video.
> Ann: I'm good on a one-to-one basis, but not with a group

(Pilot Interview 2, Excerpt:18).

The nurses were concerned about being seen as credible by the learners:

> Beth: Once you feel you know the material, you feel all right.
> I: Would you be able to voice three concerns you have about teaching your first class?
> Beth: I can think of some right now - being seen as credible. Some of these people (depending on the group) make it harder if they have had their disease for a longer period of time.
> Ann: I'm worried about being able to answer questions. That will come with experience (Pilot Interview 2, Excerpt:19).

The teaching nurses were aware of the need to involve the staff nurses in the program:

> Ruth: If we practiced our teaching on the staff nurses they might want to get more involved.
> Beth: That's the only big thing that I could see holding anybody back.
> Ruth: They are a little apprehensive, standing up in front of a group.
> Head Nurse: Yes, I appreciate that.
> Ann: I think it's mostly because they're not sure of the material (Pilot Interview 2, Excerpt:20).

The nurses were interested in the history of program adoption:

> Beth: Who first suggested it - or did you just approach them [physio]? Was it sudden or was it gradual?
> Head Nurse: No, it wasn't sudden. You know, I decided the first time that I went to the [old unit] that the nurses had to be involved in this teaching so I started slowly approaching [physio] with it. By the time we moved over here there were problems getting the individual patient treatments done. [The chief doctor] was very supportive to me. He met with the head of rehab and decided that the program should be stopped.
> Beth: I remember that I felt bad because I thought that the patients were missing out.

> Head Nurse: I did too, but a decision had to be made as to what was important, whether they needed to have their physio and their occupational therapy or teaching. In fact that decision really wasn't mine. The patients were still getting information. They still got their booklets and things like that when they went downstairs for therapy. They were missing the group interaction (Pilot Interview 2, Excerpt:21).

Finally the nurses were concerned about the impact of the program on their own personal time:

> Beth: I like my days off for myself.
> Ruth: I don't have hangups for my time or what I put out. If it was a big thing I wouldn't be here.
> Beth: I do, because my time is important. I don't mind spending a bit of time sometimes. It doesn't bother me. If it was all the time, if it was regular, it starts to bother me. I can put out only so much energy for other things.
> Ann: I think we should be compensated for the extra time that we put into this program because this is something that we are not going to take away with us. It's going to be left at the hospital. Whatever time we spend writing up programs and objectives, it's hospital property and we should be compensated. Otherwise we may find that it becomes drudgery. We started out enthusiastic. I don't think the Association wants it to become drudgery. It's important what we're doing.
> I: How do you feel about the time you've invested up to this point? Has there been a lot of preparation on your own time?
> Ann: No, we haven't been meeting very often. Like I say, I don't think that we should overdo it so that we feel kind of begrudging. If we are coming in and writing programs, we should be paid for the extra time. It's something we have to work out I guess.
> Beth: We should talk to physio about how much of it is their own time because some of them are quite involved with the Association.
> Ann: We should be compensated.
> Beth: They [physio] can arrange the scheduling of their patients differently.
> Ruth: Yes, they [physio] can just say they're not taking any patients today (Pilot Interview 2, Excerpt:22).

Characteristics of the change. The nurses discussed how the change would be paced. As far as the head nurse was concerned, the change was to occur one step at a time. Program modifications would be made:

> Head Nurse: I think we take one step at a time. Once we get the objectives down, anybody can step in at any time and give any of the lectures. We'll come up with a bunch of ideas, ways to improve, but I'm sure we'll want to even change some of these, and want to add things.
> Ann: The patients will help us.
> Head Nurse: I'm sure they will (Pilot Interview 2, Excerpt:23).

Learner outcomes. The nurses began to identify learner outcomes of the training sessions:

> Beth: The patients feel very comfortable [in the sessions] and the family does too. They feel free to speak and they get to know each other. They become a real group by the end of it. The details of their lives come out.
> Head Nurse: Yes, that first group of patients and their families really is a good group.
> I: Did they have comments? Were you able to dialogue with them at the end of the session as to how the family felt about this sort of experience?
> Head Nurse: Well, I didn't stay really [the head nurse had come in on her own time to attend this training session], but I think the charge nurse on evenings certainly got feedback. She just asked them how it went and how they liked it.
> Beth: I think you could tell they did. They really enjoyed it. It was not just getting the information, which I think they felt good about, but they really learned a lot because they could answer things like I've never seen before. They were doing all their readings so that they were keeping up with everything.
> I: Do you think they learned from each other?
> Head Nurse: Oh yes.
> Ruth: I think that's where they learned most things. They learned a few facts from us, but they learned the most from discussion in groups, within the session, about the different problems and the coping mechanisms.
> Beth: I think it turned into a support group for them (Pilot Interview 2, Excerpt:24).

## Concerns Identified During the Third Meeting

The third group meeting between the teaching nurses and the investigator occurred on June 3, 1983. The head nurse and two of the teaching nurses, Ruth and Marg, attended. The head nurse had forgotten to inform Beth of the meeting and had not been able to contact Ann (Field notes: June 3, 1983). The teaching nurses had met once to discuss implementation of the program since the last requested interview on May 6, 1983. The first two group meetings have been labelled as pilots 1 and 2 in this document. Before the third group interview, the investigator received official approval to conduct the study. This third group interview is therefore labelled as Interview 1.

Two areas of concern emerged during this third meeting and are listed in Table 5.4. The concerns focussed on the program and the needs of the nurses. The same characteristic of change emerged, that being pacing of the change. Observed learner outcomes again emerged from the data, as they had during the second meeting. The nurses in this meeting focussed on one additional area, the nature of patient teaching.

Concerns about program development and delivery. The concerns which emerged about the program focussed on criteria for selection of patients, assessment of patients, informing patients about the program, program content, documentation, and planning.

The head nurse identified the criteria which patients had to meet in order to be selected to enter the program:

Table 5.4

Concerns Identified by Teaching Nurses
During the Third Meeting

1. Concerns about program development and delivery
    - 1.1 criteria for selection of patients
    - 1.2 assessment of patients to enter the program
    - 1.3 informing patients about the program
    - 1.4 effect of old program on content
    - 1.5 need for documentation
    - 1.6 need for planning time

2. Concerns of teaching nurses about own needs
    - 2.1 group teaching methods
    - 2.2 required knowledge
    - 2.3 credibility
    - 2.4 fear of the unknown

3. Characteristics of the change
    - 3.1 pacing of the change

4. Observed learner outcomes

5. Nature of patient teaching

> Head Nurse: They have to be able to understand English, to have good hearing, and be able to sit for about an hour (Interview 1, Excerpt:1).

The nurses discussed how the assessment of these patients for entry to the program would be conducted and revealed that they expected to have more input into the assessment:

> I: You were talking about criteria. How do you identify which patients meet the criteria?
> Head Nurse: Well, lots of times it's done by nurses on admission and their [the patient's] own knowledge of their condition. Whether they know anything about it. Number one, if they are newly diagnosed, you know right away that they are candidates. Number two, you know if they start telling you quite a bit of quackery and have never been through the program. I always ask if they've been through the [old] program when they were here before.
> I: Do you feel now that you are looking at each of the patients as a candidate for the program, whereas before the program was thought of, you wouldn't have been thinking of that during admission?
> Head Nurse: Not really, because before, the rehab staff would do all the teaching, so they would make their own assessments. In addition we have rehab rounds once a week on Mondays and we go through the patients. We also make a decision with them [physio] at that time.
> Marg: Yes, it's a combination or dual effort isn't it? Occupational therapy, physiotherapy, and nursing decide who is a candidate. Also quite often the doctor may say "this patient is for the program."
> Ruth: Don't you feel [head nurse] that we have a little more input into who goes into the program than we did before?
> Head Nurse: Sure.
> Ruth: Before, you would think somebody should go into the program, but then they wouldn't be assessed for it. But now I feel that we have a little more input into it. We know who we think should go into the program as we know our suggestions are being listened to (Interview 1, Excerpt:2).

The nurses discussed how patients were to be informed about the program:

> I: Right now you have a number of patients here who you think might be good candidates for the program. Do they know that?
> Head Nurse: Not yet.
> I: What has to happen before they know that they may take the program?
> Head Nurse: Well, on Monday when we meet with the rehab staff, a decision will be made amongst us, and then the patients will be advised.
> Marg: Yes.
> I: Are they asked if they would like to take it?
> Ruth: It's suggested.
> Head Nurse: Yes, we ask them. We tell them when it is available, and when it will be conducted and we recommend it, but it is certainly their decision.
> Ruth: We do more of a sales job than actually saying "you have to take the course." It's more the benefits that are in it for them (Interview 1, Excerpt:3).

The old program had an influence on the identification and development of the content of the proposed new program:

> I: You mentioned knowledge base. From where do you plan on getting your knowledge base?
> Head Nurse: Well, we've sat through one lot of that [old] program and we have all their [physiotherapy and occupational therapy] information. The nurses individually have been doing some reading on the subject matter. I suspect that what we'll find when we start teaching is that we know more than we think we know. Would you agree?
> Ruth and Marg: Yes (Interview 1, Excerpt:4).

The need for documentation of the program was identified:

> Head Nurse: What I'll start doing is putting things in a binder to get prepared and typed. I'll start keeping the schedule. We'll start building up our file (Interview 1, Excerpt:5).

According to the head nurse, the schedule of the teaching nurses dictated how planning for the first program would proceed:

> I: Are there any special kinds of things that you are thinking about for next week in terms of the program that will run?
> Head Nurse: It very much depends on who's working what when the program is run. The last time that we thought we were going to run one, Marg was going to do the first session, I was going to do the next one, and Ann and Beth were going to do the third one, so it depends on who is working what (Interview 1, Excerpt:6).

Concerns of the teaching nurses about their own needs. The teaching nurses again expressed concerns they had about being involved in teaching the program. The concerns focussed on teaching methods, knowledge, credibility, and fear of the unknown:

> Marg: Now I'm a little scared. We all are. It's a new thing for us. But I'm certainly hopeful and very enthusiastic about it.
> I: Have you been able to put your finger on or sort out the kinds of things that you are a little anxious about regarding the program? You said you were a little scared?
> Marg: Oh well, it's just the group. It's easy for us on a one to one basis. And the subject matter, I'm not clear on that yet. I haven't been to all the lectures so just to know what I'm talking about, to be sure of what I am talking about.
> Ruth: I think it's that first run, it's like doing anything for the first time. The first time we sat in here, you wonder - what am I going to do? Am I going to do it right? I think that's the feeling I have. I'm not really scared about the knowledge part because you have to learn to say "I don't know, I'll find out but I don't know." I think it's that first run, to get the first run through, to know where we can make the program better ourselves, because we've each seen it and we each know the little areas we'd like to change, but can we do it effectively (Interview 1, Excerpt:7)?

The head nurse reassured the teaching nurses:

> Head Nurse: I can remember the first time I taught. I was very frightened. You study as much as you can, but I think as Ruth says, it's the first time in front of the group. Once you start talking your fear goes away and you realize "hey, I can do it." We'll make mistakes, I'm sure we will. That will be O.K. (Interview 1, Excerpt:8).

Characteristics of the change. The first classes would be a trial run, the nurses would play it by ear, and changes would probably occur throughout implementation of the first program:

> Head Nurse: When we met the last time we tossed it [implementation of the first program] around a fair bit and decided that it would be a trial run. We weren't going to set things in stone. We'll just play it by ear. Am I right?
> Ruth: That's right.
> Head Nurse: And we realized that as time went on there are things that we would probably want to include or maybe delete. We will just have to play it by ear. I worked on a page of stuff so it's more structured (Interview 1, Excerpt:9).

Expected learner outcomes. In addition to the learner outcomes of feeling good, gaining group support, asking questions, and doing readings, which the nurses had observed during the training session and had discussed during their second meeting, they now identified other observed and expected learner outcomes of implementing the program. These were acceptance, hope, and compliance with the prescribed exercise program:

> I: You mentioned benefits. What do you see as the benefits of the program for the patients?
> Marg: For me it's the patient's acceptance. That's what I zero in on and a lot of us do. I think that most of us pick up on that and try to help them with acceptance of the disease, don't we?
> Ruth: I think that a lot more times they will follow an exercise program in the regimen. Rather than laying there they are doing an exercise. It's part of the acceptance.
> Marg: The patients benefit so much from it. They don't feel so hopeless, it gives them some hope - and I don't think it's an unrealistic hope either - that they can cope with their disease (Interview 1, Excerpt:10).

Nature of patient teaching. Although the nurses had always been doing patient teaching, anticipation of their involvement in the program made them more conscious of their teaching activities:

> Ruth: I think we do a lot of subtle teaching on the ward when we really don't realize we're teaching. We're doing a lot of program teaching even if there isn't a program. I know I am anyway. I'm more conscious of the teaching I am doing. You have to teach every day. Well, you don't have to, but you teach every day in some way, I'm more conscious of it (Interview 1, Excerpt:11).

This third meeting occurred on June 3, 1983. Eleven days later, on June 14, 1983, the nurses taught the first class of the program.

## Discussion of Planning for Implementation

No clearly identifiable factors which appeared to have influenced the stage of Planning for Implementation emerged from the data. Although it seemed far too early to identify such influencing factors, some impressions or insights about this stage, however, did begin to emerge as the investigator listened to the nurses and began to analyze the data. The impressions are listed in Table 5.5 and are discussed in this section of the chapter.

### Initial Concerns of the Teaching Nurses

The concerns which the teaching nurses discussed during the three group meetings are summarized in Table 5.6. Three features of the discussion are particularly noteworthy. First, on the whole, the same general concerns were identified by the nurses in all three meetings. Five broad areas of concern were identified in the first meeting. As

Table 5.5

Impressions About Planning for Implementation

| Impressions |
|---|
| 1. The teaching nurses identified concerns about implementation very early in the "planning for implementation" stage. |
| 2. The teaching nurses demonstrated motivation and commitment during the "planning for implementation" stage. |
| 3. The teaching nurses identified observed patient outcomes in the "planning for implementation" stage. |
| 4. Antecedent conditions influenced the "planning for implementation" stage. |

**Table 5.6**
Initial Concerns of the Teaching Nurses

| Concerns Identified in First Meeting (Ann, Beth, Ruth) | Concerns Identified in Second Meeting (Ann, Ruth, Beth, and Head Nurse) | Concerns Identified in the Third Meeting (Ruth, Marg, and Head Nurse) |
|---|---|---|
| 1. Mechanics of Implementing | 1. Program development and delivery<br>• assessment tools<br>• content<br>• standardization<br>• scheduling<br>• coordination with other departments | 1. Program development and delivery<br>• criteria for patient selection<br>• assessment of patients<br>• informing patients<br>• content<br>• documentation<br>• planning/scheduling |
| 2. Program Content | 2. Learners<br>• involvement in own learning<br>• reinforcement<br>• family involvement | 2. Nurses' Needs/Fears<br>• group teaching<br>• knowledge<br>• credibility<br>• the unknown |
| 3. Additions required to augment old program<br>• evaluation | 3. Nurses' Needs<br>• planning time<br>• teaching methods<br>• credibility<br>• staff nurses involvement<br>• history of adoption<br>• personal time/compensation | 3. Characteristics of the change<br>• pacing of the change<br>• learner outcomes<br>• nature of teaching |
| 4. Needs of Learners | 4. Characteristics of the change<br>• pacing of the change<br>• learner outcomes | |
| 5. Nurses' Fears and Frustrations<br>• teaching methods | | |

evidenced in Table 5.6, these same concerns continued to be discussed during the subsequent meetings. The second feature of the discussions was that with each subsequent meeting additional variables or issues related to the concern began to emerge. These variables can be traced across Table 5.6. For example, in the first meeting, the nurses generally wondered how hard it would be to implement the program (Pilot Interview 1, Excerpt:3). In the second meeting, the nurses struggled with specific problems of implementation such as scheduling. Concerns about scheduling the nurses to teach while taking into account days off, holidays, and work on the unit (Pilot Interview 2, Excerpt:8), scheduling the patients and families to receive the program while taking into account travel distance to the hospital and other family/work life responsibilities (Pilot Interview 2, Excerpt:9); and scheduling the program so as not to interfere with the schedules and functions of other hospital departments (Pilot Interview 2, Excerpt:9) emerged. In the third meeting, the head nurse decided that delivery of the program would be somewhat contingent on the schedules of the teaching nurses (Interview 1, Excerpt:6). Other examples of where discussion during the three meetings led to the identification of additional influencing variables, are evident in Table 5.6. These were in the areas of learner needs and nurse needs.

A third feature of the initial discussions, which is illustrated in Figure 5.1, was that three types of concerns emerged. First, the nurses wanted more substantive information about scheduling, content development, standardization of content, need for documentation, and development of assessment tools. Second, the nurses were concerned

| Substantive/Informational | Impact on Others | Personal Impact |
|---|---|---|
| • Teaching methods | • Involvement of staff nurses | • Knowledge |
| • Planning time | • Coordination with other departments | • Personal time |
| • Documentation | • Needs of learners | • Compensation |
| • Assessment of patients | -involvement | • Credibility |
| • Criteria for patient selection | -reinforcement | • Fear of unknown |
| • History of the adoption | -family | |
| • Assessment tools | | |
| • Scheduling | | |
| • Standardization | | |
| • Content | | |

**Figure 5.1**

Types of Initial Concerns of the Nurses

about the impact which implementation would have on other participants in the change, such as the learners, the families, other departments, and the staff nurses. Finally, the teaching nurses were concerned about the personal impact which the change would have on themselves. They talked about being seen as credible, about compensation, about infringement on their own time, and about fear of the unknown or fear of doing something for the first time.

The types of concerns resembled what Hall and Loucks (1982) had identified as the stages of concern (Figure 5.2) about an innovation. The concerns which emerged during the initial three meetings with the teaching nurses are compared, in Table 5.7, with the concerns which Hall and Loucks identified. As noted in Table 5.7, the nurses were beyond the stage of awareness at the time of the initial meeting. However, during the initial meeting, the nurses raised concerns which fit into five of the remaining six stages of concern. Only the stage of refocussing remained untouched during all three initial meetings with the nurses. Also evident in Table 5.7 and congruent with the work of Hall and Loucks (1982) was the finding that the emergence of the concerns was not progressive. On the whole, the same concerns emerged during each meeting. However, as previously stated, the concerns were discussed in increasing detail during each subsequent meeting.

Clearly, the teaching nurses had identified some concerns about implementation which to them were very real. The investigator was left to wonder at this early stage which, if any, concerns would indeed become issues that would later threaten the successful

6. REFOCUSING: The focus is on exploration of more universal benefits from the innovation, including the possibility of major changes or replacement with a more powerful alternative. Individual has definite ideas about alternatives to the proposed or existing form of the innovation.

5. COLLABORATION: The focus is on coordination and cooperation with others regarding the use of the innovation.

4. CONSEQUENCE: Attention focuses on impact of the innovation on students in his or her immediate sphere of influence. The focus is on relevance of the innovation for students, evaluation of student outcomes, including performance and competencies, and changes needed to increase student outcomes.

3. MANAGEMENT: Attention is focused on the processes and tasks of using the innovation and the best use of information and resources. Issues related to efficiency, organizing, managing, scheduling, and time demands are utmost.

2. PERSONAL: Individual is uncertain about the demands of the innovation, his or her inadequacy to meet those demands, and his or her role with the innovation. This includes analysis of his or her role in relation to the reward structure of the organization, decision making, and consideration of potential conflicts with existing structures or personal commitment. Financial or status implications of the program for self and colleagues may also be reflected.

1. INFORMATIONAL: A general awareness of the innovation and interest in learning more detail about it is indicated. The person seems to be unworried about himself or herself in relation to the innovation. He or she is interested in substantive aspects of the innovation in a selfless manner such as general characteristics, effects, and requirements foruse.

0. AWARENESS: Little concern about or involvement with the innovation is indicated.

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**Figure 5.2**

Stages of Concern About the Innovation

Reproduced from "Measuring Stages of Concern About the Innovation: A Manual for Use of the SoC Questionnaire" by G. E. Hall, A. A. George, and W. L. Rutherford, RDCTE, 1977.

## Table 5.7
Comparison of Initial Concerns that Emerged in the Present Study
With Stages of Concerns (Hall and Loucks:1982)

| | Concerns Identified in Initial Meetings in Present Study | | |
|---|---|---|---|
| Stages of Concerns | Meeting 1 | Meeting 2 | Meeting 3 |
| Refocusing | | | |
| Collaboration | | • coordination with other departments | • criteria for patient selection<br>• assessment of patients |
| Consequence | • needs of learners | • staff nurse involvement<br>• learner involvement<br>• family involvement | |
| Management | • mechanics of implementation | • scheduling<br>• reinforcement of teaching<br>• planning time<br>• practice teaching<br>• assessment tools | • group teaching<br>• criteria for patient selection<br>• assessment of patients<br>• informing patients<br>• documentation<br>• planning time<br>• scheduling |
| Personal | • amount of time required<br>• knowledge of patient teaching | • compensation<br>• credibility<br>• impact on own time | • knowledge<br>• credibility<br>• fear of unknown |
| Informational | • content<br>• evaluation | • content<br>• standardization<br>• history of adoption | • content |
| Awareness | not applicable | | |

implementation of the program. The investigator was reminded of the work of Fuller (1969) on the concerns of beginning teachers and the work of Hall and Loucks (1982) who adapted her ideas and used them to study implementation. Hall and Loucks (1982:39) reported: "It seemed as if one could almost predict the entire scenario of how change would unfold . . . based on the initial inquiries and questions heard during the first site visit."

Motivation/Commitment of the Teaching Nurses

During this Planning for Implementation stage, the nurses indicated that they were motivated and committed to the successful implementation of the program. Six factors emerged from the data and appeared to have motivated the nurses. First, the nurses had chosen to work on unit Y because of the innovative mandate. Second, they could identify reasons why they believed that as nurses, they should be involved in teaching the program (Pilot Interview 1, Excerpt:1 in Chapter 4). Underlying that belief seemed to be the third factor, a need to be seen by the patients as more knowledgeable, more credible, and to be seen as more of a resource person than had been the case prior to their involvement in the program (Pilot Interview 1, Excerpt:1 in Chapter 4). Fourth, it seemed that the nurses could identify areas of the old program in which content revision or additions were required (Pilot Interview 1, Excerpt:6 and Pilot Interview 2, Excerpt:2). Fifth, they had recognized the content areas in which they would be required to gain more knowledge and seemed willing to invest the required time and energy to research the lecture topics (Pilot Interview 2, Excerpt:2 and 3). The nurses became most animated, enthused, and concerned when discussing the benefits of the program for the patients and families (Pilot Interview 2, Excerpt:13, 21, 24 and Interview 1, Excerpt:10). In fact, the investigator had the feeling that the factor which primarily motivated the teaching nurses at this early stage, was the prior observation of and the expected observation of patient and family outcomes.

However, two factors emerged which appeared to have the potential to threaten the commitment and motivation of the nurses. These factors seemed to somehow be related to the lack of clarity about certain aspects of implementation.

First, there was a lack of clarity about substantive issues, particularly content and scheduling. The nurses tried to impress on the head nurse their need to know what content to teach, to identify what learning was required in order to teach the undetermined content, and to know what content had been taught in the old program (Pilot Interview 1, Excerpt:5; Pilot Interview 2, Excerpt:2, 3, 4 and Interview 1, Excerpt:7). The nurses sought clarification about how the program would be scheduled, and as previously discussed, had identified variables that would have an impact on scheduling (Pilot Interview 2, Excerpt:8, 9, and 10). The investigator had to wonder at this point how the teaching nurses would ever be able to teach the first program without reaching some resolution of these issues.

The second factor which appeared to have the potential to threaten the motivation or commitment of the teaching nurses was a lack of clarity about the personal impact that implementation would have on the nurses themselves. The nurses could not elicit from the head nurse any clear indication of the amount of materials preparation time that would be required, of whether planning for implementation and practice teaching time would be available, which time expenditures on their part would be compensated, in what form the compensation would be, and who would have ownership of produced materials (Pilot Interview 1, Excerpt:3, Pilot Interview 2, Excerpt:14, 15, 16, 18 and 22). Factors had emerged which appeared to have motivated the nurses to become involved in teaching the program and it seemed clear that the nurses were committed to the program. However, factors had also emerged which seemed to have the potential to threaten this commitment. The investigator, at this early stage of implementation, began to wonder if the level of commitment could be maintained over the course of program implementation given the potentially offsetting effects of these threatening factors.

### Identification of Learner Outcomes

The teaching nurses could identify very early some learner outcomes of implementing the program. The learner outcomes are listed in Table 5.8. It seemed that the nurses could identify these outcomes because they had observed the effects of the old program over a period of time and more importantly, they had observed the behaviors of the patients during and after the training sessions. As previously indicated, it seemed that this ability to observe learner outcomes had in fact become the prime motivating factor for the teaching nurses to become involved in the program.

Table 5.8

Learner Outcomes Identified During "Planning for Implementation"

| Learner Outcomes |
|---|
| 1. Feel good about themselves |
| 2. Able to answer questions about their disease |
| 3. Read about their disease |
| 4. Aware of difficulties associated with the disease |
| 5. Aware of group support |
| 6. Aware of mechanisms to cope with the disease |
| 7. Accept the disease |
| 8. Comply with an exercise program |
| 9. Gain a sense of hope |

## Influence of Antecedent Conditions

The teaching nurses and the head nurse identified the fact that one antecedent condition in particular was affecting the new program. That condition was the existence of the old program. The teaching nurses identified three components of the new program which were being affected by the old program.

First, the nurses recognized early in the first meeting that the content of the program had been developed by someone else (the rehabiliation team) and that the nurses were "jumping into their bag" (Pilot Interview 1, Excerpt:5). However, the existence of this content did not appear to offer much reassurance to the teaching nurses. They had already identified areas of content which required change or revision (Pilot Interview 2, Excerpt:2). In addition the nurses continued throughout the three meetings to discuss their concerns and exhibit lack of confidence over the precise details of the content (Pilot Interview 1, Excerpt:5, Pilot Interview 2, Excerpt:2, 3, 5, 6, 7, 8, 19, 20, and Interview 1, Excerpt:7). This concern about content on the part of the teaching nurses was not unexpected when one remembers that all the teaching nurses had not attended all of the training sessions, nor had they seen a copy of the old teaching program. The teaching nurses requested that they each be given a copy of the old program (Pilot Interview 2, Excerpt:7), but this was not done.

The head nurse, however, attempted to reassure the nurses by suggesting that they probably knew more than they thought they did (Pilot Interview 2, Excerpt:4), that they would have the content of the old program to fall back on (Pilot Interview 2, Excerpt:4), that they would tailor the program to their own needs (Pilot Interview 2, Excerpt:4), that their confidence would increase as they got into the program (Pilot Interview 2, Excerpt:8) and that this kind of lack of confidence and concern was a normal reaction to teaching anything for the first time (Interview 1, Excerpt:8). In the mind of the head nurse, the teaching nurses would utilize the content of the old program and introduce modifications where necesary.

The second component of the new program which was affected by the old program was the set of criteria for patient selection. The rehabiliation team had been primarily responsible for selecting patients for the old program. At this early stage of implementation, they continued to be involved in selecting the patients and in identifying the criteria which patients had to meet in order to attend the program (Pilot Interview 2, Excerpt:6, and Interview 1, Excerpt:2 and 3). While discussing patient selection for the new program, however, the nurses began to hope that they would have more input into which patients were selected for the program (Interview 1, Excerpt:2).

The existence of the old program seemed to have one final, though indirect, influence on the new program. It seemed that because of the existence of content of the old program, the head nurse assumed that little time was required for the teaching nurses to develop content, that the teaching nurses required minimal expert guidance regarding the technical apsects of developing the program, that little time for meeting together to plan for implementation or to practise group teaching was required, and that schedules could be decided almost at the last minute. It seemed to the investigator, particularly in the second meeting, that the teaching nurses were seeking clarification, expert guidance, and commitment from the head nurse about these issues.

## Summary of Planning for Implementation

In summary then, certain impressions about planning for implementation had emerged. These impressions focussed on the initial concerns of the teaching nurses, the motivation of the nurses, the ability of the nurses to identify learner outcomes, and the influence of antecedent conditions on the new program. At the conclusion of the three meetings, the investigator was curious about whether the teaching nurses would remain committed to the program given some rather obvious areas of ambiguity and whether problems would occur during implementation over such issues as the use of the old content, the identification of criteria for patient selection, and lack of development time.

What happened as the nurses implemented The Trial Run is discussed in the next chapter.

# CHAPTER 6

# IMPLEMENTATION OF THE FIRST FIVE PROGRAMS: THE TRIAL RUN

## Introduction

The nurses taught one program five times between June 14 and November 27, 1983. The head nurse had indicated that implementation of the first programs would be a Trial Run. Therefore, the five programs that were taught in the six month period, have, in this study, been labelled "The Trial Run" and are described in this chapter.

The chapter is divided into three sections. First, in the overview section, the events which occurred as the nurses delivered the first five programs are described. The factors which influenced implementation are discussed in the second section. Finally, a summary of the chapter is provided in the third section.

Before proceeding to read the chapter, three notes of caution are in order. First, the chapter is long and complex. This, in the opinion of the investigator after much deliberation and numerous pilot formats, was the preferred method of presentation for a number of reasons. It is the intention of the investigator to let the data itself "speak to the readers." The investigator expects that readers will be "placed in the setting"; will become "immersed" in the data; will "hear" the teaching nurses discuss their successes and failures and their moments of happiness, fear, and frustration; will "hear" the nurses report on the patients' struggles to cope with and learn about their long-term illness; and that readers will "draw their own conclusions" and will "hypothesize" about what happened while the first five programs were implemented.

In addition, it is the intention of the investigator that readers will become aware of the research process which emerged while the study was in progress. The investigator expects that readers will see new informants be generated by the data; will become aware of ethical issues; will recognize examples of fact-seeking, probing, paraphrasing, verifying, responsive and speculative interviewing techniques; will appreciate the value of detailed field notes; will hear informants "think and make decisions on their feet"; will be a witness as the investigator tries to establish validity of the data and reliability of the informants; and that readers will gain a better understanding of how impressions emerge to become conclusions and hypotheses. These intended outcomes could not be realized if the investigator had shortened or divided the chapter.

The second note of caution is that the chapter contains long transcript excerpts. Readers can approach the chapter in one of two ways. They can quickly proceed through the chapter by reading only the "lead-in" sections to each excerpt. The "lead-in" section contains the essential ideas or main themes of each excerpt. As in Chapters 4 and 5, the main theme of each excerpt has been underlined. If however, readers are to realize the intentions of the investigator and become immersed in the data, and if readers wish to corroborate the evidence on which the findings and conclusions presented in the discussion are based, they will prefer to give the excerpts more than a passing glance.

The third note of caution is that the meaning of a given term changes as the chapter unfolds. The nurses used the terms "class", "session" and "lecture" interchangeably to usually mean the lesson they taught in the classroom to the group of patients. However, they also refer to the experience which occurred in the classroom as "the class" (eg: "it was a good class"). In most cases the investigator, when reporting the data, used the same terms as had the informant. On the whole, the meaning is clear in the context of the excerpt. In addition, the nurses begin the chapter by reporting about developing the "module", meaning the lesson plan, and end the chapter by reporting about developing the "teaching unit". This change in terms was a function of the developmental nature of the change process which was under study.

What happened during implementation of the five programs is now described in the overview section.

## Overview of the Trial Run

The events which occurred during the Trial Run are listed in Table 6.1. The nurses taught one program five times between June 14 and November 27, 1983. Reports of the nurses about what happened during the trial run are presented in this overview section. The overview section itself is divided into five subsections, each describing the delivery of one of the five programs. Implementation of the first program is discussed in the first sub-section.

### Implementation of the First Program (June 14 - 23, 1983)

The first program was taught from June 14 to 23, 1983. According

Table 6.1

Implementation: The Trial Run

| Time - Line 1983 | Events |
|---|---|
| June 14 - 23 | . Nurses teach the first program |
| June 30 | . Head nurse announces she is resigning<br>. Head nurse chooses a staff nurse to be the acting head nurse |
| August 12 | . Head nurse leaves unit Y |
| August 15 - September 2 | . Nurses teach the second program<br>. Head nurse appoints Ann to co-ordinate teaching program |
| August 22 - September 5 | . Acting head nurse on vacation |
| September 6 - 23 | . Nurses teach the third program |
| October 24 - November. 4 | . Nurses teach the fourth program |
| October 24 | . Meeting among teaching nurses, director of nursing services, acting head nurse and area supervisor |
| October 26 | . Meeting among teaching nurses, physiotherapist, occupational therapist, and the acting head nurse |
| November 14 - 25 | . Nurses teach the fifth program |
| December 5 | . Ann begins a week of planning and program development activities |

to the proposed format (Figure 4.1 in Chapter 4) the nurses would give three lectures over a two-week period. The first lecture would include an introduction to the disease and the showing of a film. Stress would be the focus of the second lecture. The third lecture would involve a discussion of quackery.

The proposed format was not implemented. The head nurse and Marg gave the first two lectures. However, the patients were discharged before Beth could deliver the third lecture. After the first program had been implemented, the head nurse reported that she was resigning.

Each of the nurses, except Ruth who was on holidays, reported on implementation of the first program. Marg was on duty and left the floor for one hour to give the introductory lecture. The head nurse came back to the unit during her time off to teach about stress. Ann and Beth, who both worked part-time, had planned to teach quackery together. However, Ann was not scheduled to be working at the time that the third lecture was to be given. She had made other personal commitments and therefore did not come in to teach in the first program. Consequently, Beth was faced with the prospect of teaching the third class alone. Beth's feelings about implementation of the first program are now reported.

Report of Beth prior to teaching her first class. Beth was interviewed two days after teaching had commenced and one week before she was scheduled to give the third and final lecture of the first program. One week prior to the interview, Beth had been asked by the head nurse if she would teach a class in the first program. During the interview Beth discussed her reaction to implementation of the program and gave an in-depth account of her thoughts and feelings prior to teaching her first class.

Beth felt uneasy about teaching her first class alone:

> Beth: I thought that I'd be doing it with one of the other girls [Ann]. She can't do it that night, so I'll be doing it myself. [The head nurse] knew I was leary of doing that. She said she would come along for the session. I don't know if that will be worse, or better. I think I would sooner be alone now (Interview 2, Excerpt:1).

Beth had attended only one training session. Coincidentally, it was the session which she would be teaching in the first program. However, she still felt unprepared to teach her first class:

> Beth: I'd prefer to have more time to get prepared because we haven't fully planned the whole session. We have the rough outline from before [the old program]. We discussed a few things and we got a bit more information but we haven't put it all together, I haven't gone through it in my mind (Interview 2, Excerpt:2).

Beth wanted to get some feedback from Marg and the head nurse about the classes they taught:

> Beth: On Tuesday Marg did the introduction and the film. I don't know how it turned out because I haven't talked to her. Now I don't know if I'll be able to stay even to see how [the head nurse] does. I'll talk to her certainly before I teach my session. I do want to see how it went.
>
> I would like to have been at the classes that were started this past week, to have attended all of them. Some were on my days off. I could have come in but I didn't want to. I had plans. If I had attended all of them I would be using almost every day of the week for doing that or coming to work. I'm not willing to do that much (Interview 2, Excerpt:3).

However, Beth found it difficult to obtain feedback from the other teaching nurses:

> Beth: Our rotations are switched. We are seeing each other all at different times. It's hard to pass information on and ask people things. When we're busy on the floor and there are only a couple of you, we don't have time to sit. We don't want to talk about work, we talk about things unrelated (Interview 2, Excerpt:4).

Beth identified some factors which were contributing to her anxiety about teaching the first class. She had not done any group teaching since leaving university, she had little time to prepare, and she questioned her own credibility:

> Beth: First, I haven't done anything like this since I was in university. Also, I would usually spend more time preparing. Another thing is they [the patients] are mostly older people and I appear very young to these people. They probably see me as being not quite credible. I'm worried about how they will take me. Will they think I am believable or not? Then there's the thing about getting up in front of a group of people (Interview 2, Excerpt:5).

Beth felt out of touch with the program. She had not been on the unit during the week before teaching had commenced, did not know the patients she would be teaching, and was not nursing the patients to whom she would be giving the lecture:

> Beth: I haven't been on all week. This is the only day I've been on. I'm off for four days. I'll be on next Tuesday and Wednesday, the two days before [I teach]. That might give me a chance to be around people and test their reactions to what they have learned. Other than that I've only had this one day to be here and my patients, the ones that I have, aren't involved [in the program]. It's a scary period. I came into it cold. The last time I was on was on the weekend, a lot of patients were out on pass. I just feel like I am completely out of touch with everything. That makes one more anxious (Interview 2, Excerpt:6).

She discussed her reactions to the delay of implementation. She felt frustrated. The planning had lacked continuity and there had not been enough planning:

> Beth: It's strange. We'd talk about it once and sort of get excited about it. Then, two or three weeks would go by, with not another word said. You'd just come to work, do your thing, go home. Then something more would be said about it and you get excited again. It's been so up and down and off and on that I've had a hard time feeling like it's together. I feel it's very haphazard, no continuity. We had one meeting where we were going to start the program up. Then we realized that perhaps we didn't have the right combination of patients, and not the right amount [of patients]. I felt like we'd gotten something rolling. We got the objectives written out for one session, we discussed it and that was it. We never got together again. I don't know what's been good about the way we've done it, I can't see any organization to it. The stops and starts have bothered me. Then when it comes up again you think "Oh, is this for real?" I don't feel like I've been involved, I've lost that. Perhaps once I get into teaching the session, then I'll feel part of it (Interview 2, Excerpt:7).

Beth had some suggestions for how planning for implementation of the first program should have proceeded. The nurses should have met for a week to plan, develop, and review the program:

> Beth: We should have set aside one week, whether it was hard or not, to get together. We should have made a point of forcing ourselves to get together for the full week so we had everything ready, organized, finished and complete, so we knew where we stood. Then no matter when it started, it would all be there and ready to go. Then we would have had a chance to review everything just to feel comfortable about it. It's not a complicated thing. We've taken on very simple sessions. It shouldn't be that difficult. It's haphazard, off again, on again. We decided to maybe do this, and decide three or four days ahead of time or a week or two ahead of time when to do which, and then still change our mind two days before. I'd say "Have it all done at one time and then it's done". (Interview 2, Excerpt:8).

Beth discussed the guidance and support which the teaching nurses were receiving. She was not sure whether there had been much support or guidance from the head nurse or between the teaching nurses:

> Beth: [The head nurse] should be the guiding force. In a way she is, but she's got so many things. She doesn't do things all at once and get them done. She starts and stops. I don't know if there's been that much support or guidance among any of us to each other, much less her to us. I thought it would be more organized. Mind you, we all should have perhaps taken a bit more control there (Interview 2, Excerpt:9).

Beth was concerned about teaching on her days off. She needed the time to recover from work and to prepare for the next shift. She also questioned the procedures of payment and the amount of recognition which the hospital gave to the program:

> Beth: When I come in, it will be on my day off. [The head nurse] said, "Do you mind?" I said, "Well, I prefer not to [teach] on my day off, because I work for two days and I only have one and a half days off, because I come on to nights. Then I work the weekend." She said, "I'll talk to Ann and see if she can." Ann was working [at something else]. So it was up to me to do it. She said, "Of course I'll pay you for your time." Now, how is she going to pay for that time? What she told us before was that it would come out of money that was given by the Association. I don't understand how that is working on our pay slips. How do they mark that in? Marg, when she did her session, was on duty that day and she had to leave the floor. If they were busy on the floor, I would think it could make a difference even if she is gone for an hour, one person short, when there's only a couple on evenings. Quite frankly, that's the way I thought it would be. I couldn't see how we would be able to get relief, because the hospital doesn't recognize this program. It's our own thing and there's no consideration given to staffing. You hope you're not busy that night. See it doesn't always work out the way they say it's going to. They say we'll give you time to do this and that. When I get together with Ann on Monday or Tuesday to discuss the session which I'm going to teach, that will be on my own time and her own time. We won't be paid for that (Interview 2, Excerpt:10).

Beth discussed her hopes or expectations for the program. She thought that more patients should be involved, that more classes should be taught, and that more staff should be involved:

> Beth: I'd like to see it [the program] really develop into something, so that we have more sessions, so that we can get more patients involved (larger groups of them) because there are a lot [of patients] that go through without the benefit of it. They get good information from physio and O.T. but they don't get the whole thing in sequence and I don't think they get as much. There are so many people who could use the information. I was just talking to a patient today who had [the chronic illness] for 18 years. If she had done things differently she might be in better shape now. I'm sure that there is a lot of that still happening. I'd like to see more sessions, more patients involved and more staff involved. If this floor is to be a teaching unit, well, I think it will take a long time (Interview 2, Excerpt:11).

Beth attempted to identify some expected learner outcomes. She had not identified these outcomes prior to the interview. The patients' quality of life may improve, the understanding of the family may increase, and the number of admissions to the hospital by the patient may decrease:

> Beth: I always think that a person can never have enough knowledge. With knowledge you have more opportunity, combined with experience, to gain wisdom. You would know how to change your life style or to adapt so that your actions are - I don't know - would it be more conducive to constructive living? Many of them are struggling, and are not living the same quality of life I think they could with more information, knowledge of treatment, and just understanding why something is happening to them. Help them so they aren't as frustrated. Then you would see happier people, people who are more content. Maybe if their families were being educated they might have fewer problems. Maybe you'd see less hospitalization. Often people come into the hospital because they have these symptoms and they're scared and they don't know. They just want to get away from a family situation that doesn't understand them. They want to be somewhere where they can relax and get away from it all.

> If their families understand what is going on, maybe they won't be here as often. If they have more correct information, they can spread the knowledge. I don't really know specific things. It might just be a change in the general attitude of the person (Interview 2, Excerpt:12).

She also attempted to identify what personal outcomes might result from her involvement in the program. Some idealistic outcomes could emerge in addition to the practical outcome of improved career opportunities:

> Beth: It all sounds so idealistic. Some days you get enthusiastic about your work. You'd like to think you'll be involved, that you're making a difference, making a change. I could say that we could become more involved with our jobs, we could be working together as more of a group, we could feel closer to our patients, we could have more kinship with some of the other professionals in the hospital. But to tell you the truth I don't know what kind of change there would be if any. Sometimes you'll have interest, sometimes you won't. Maybe it won't make a difference that way. In practical things it might be good for other work. We could go some place else and put on a resume that "I was involved in the teaching program" or it could make some people personally more confident of their abilities, you know a subject area better, you have done a few things other than routine care. I don't know, it's hard to say. I doesn't always turn out the way you think (Interview 2, Excerpt:13).

Beth did not teach the third class as planned. The program patients were discharged on the morning of the final scheduled class day to allow for admission to the unit of acutely ill patients who did not have the chronic illness.

The head nurse, Marg, and Ann were individually interviewed after the first program had been taught. Marg and the head nurse had taught the first two classes. Ann had not taught; however, she had been working on the unit in days which followed the sessions. Therefore, the investigator felt that her reports about implementation of the first program would be worth capturing in addition to those of the head nurse and Marg.

Reports of the head nurse, Marg, and Ann following implementation of the first program. Each of the three nurses were asked the same general question about implementation of the first program.

> I: What are your impressions about implementation of the first program?

The response of the nurses focussed on observed patient behaviors, on the need for the program, and on certain aspects of the program delivery:

> Ann: I didn't teach in the first program, but I have been on the unit. I did talk to some of the patients about the stress lecture. They remarked that there was one lady who had been discharged before the lecture took place. They felt so bad that she had missed out on it because she had problems in her personal life and could have benefitted. I have talked to other patients, too, who seemed to have a lack of understanding in their families, especially husbands. We had one patient (I don't believe she got in on the lecture on stress) who had a husband who felt that some of her problems were psychological. She was in a lot of pain. She was in [an acute stage]. Her husband also had a friend who was a psychologist and the two of them would get together and talk down about her condition and thought she should get her act together and things would be all right. It made me feel bad, she wasn't in very long and I know she was on the phone many times crying. I tried to get close to her and talk to her and explain things to her. I did a bit of teaching on a one-to-one basis with her. I really did see a need. These lectures are necessary (Interview 5, Excerpt:1).

> Head Nurse: Well, I certainly didn't have any problems with it. I'm not aware that I had any particular feelings other than being happy that it was done, myself enjoying the experience, and getting the feeling from the patients that it was a worthwhile thing. It was a good group, particularly the husband of one of the patients who was there. They

> seemed to have some problems. I was hesitant to probe any further during the session. I picked that up just in terms of what the husband was saying (Interview 4, Excerpt:1).
>
> Marg: It was a little hairy in the beginning because I forgot. I remembered it [the session] before I came to work. I forgot all about it after I got to work. One of the patients came and asked if we were going to show the movie. I had to get into [the head nurse's] office and get the tape and set it up. It was a little nerve-wracking. Once it got going, it was fine. The patients seemed to identify a lot with the girl [in the movie] and the hard time she was having. The patients, the women and one man, brought out their bad times and how they managed to cope with their illness. It was a moving discussion. I came away feeling that it was a good experience. We asked the husband of one of the patients how he felt about it. He shared his problems, that sometimes it was hard for the whole family. I enjoyed it and I felt that the patients did too. It brought us closer together instead of a nurse-patient relationship. I felt closer to the patients and I think they felt closer to me (Interview 6, Excerpt:1).

The nurses discussed how they had prepared to teach the class. Marg and the head nurse had been prepared to let the patients establish the tone of the class. Ann felt prepared. The three nurses reported:

> Marg: I had some partial objectives, not really objectives but possible questions or topics. I was hoping to and we did talk a lot about acceptance because I think it's number one in any disease, in any part of our life. I didn't think "Oh, what am I here for and what do I want them to do?" I focussed on acceptance and we talked about that (Interview 6, Excerpt:2).
>
> Head Nurse: I had outlined the objectives and the content that I wanted to cover. I went ahead and used the group to get things going. The group really led the session. I just threw in a few questions, and a few pointers to facilitate matters. They sort of took off (Interview 4, Excerpt:2).
>
> Ann: I haven't asked when the next program will be taught. If I'm available I would certainly be willing [to teach] and I would hope that I would be included. I would expect to be included. I definitely feel prepared to teach. I could run with it (Interview 5, Excerpt:2).

Marg identified some of *her own outcomes* to teaching the session. She felt on a peer level with patients and felt closer to them:

> Marg: I thought it was very valuable.
> I: Were you able to identify what were the valuable parts of the experience for you?
> Marg: I felt closer to them, just sharing the experience. It was off the unit, it wasn't a nurse-patient relationship. I had shared that I had [a chronic illness]. I know a bit how they feel. They were giving me advice on what to do for my illness. It made them feel a little bit better I think. The closeness of a group experience and the sharing is always nice. To me an illness is about one of the hardest things to talk about in front of other people. I found it valuable in getting to know patients on another scale from nursing, knowing them on a peer level and experiential level (Interview 6, Excerpt:3).

The nurses discussed the *reactions of the patients* to the program. The patients enjoyed the class, were able to focus on specific aspects of their illness, and were forced to take a realistic look at their illness:

> Head Nurse: I think that they really enjoyed it. I'm not sure that I necessarily gave them new information. I helped them to focus a bit more on the types of things that they need to pay attention to in terms of tension, stress related to their [illness] (Interview 4, Excerpt:3).
>
> Marg: One lady who was new to the program, who had just been diagnosed a couple of months previously, cried and talked a lot. It brought her out and made her look at it. Now, I think she was probably in the denial stage of the disease but she was forced to look at it. I think it was a good thing for her. Seeing the movie was hard for her but at the same time it was a realistic look at it as a disease. I think it was good to hear everyone else and be able to share it (Interview 6, Excerpt:4).

The nurses had difficulty reporting on the specific reaction of the patients to the class because they did not communicate with the patients after the class:

> Head Nurse: I can't answer that because I was away. I came in just to do that class. I saw them right after the class. I didn't see them the next day. The staff said the patients enjoyed it, but nothing more specific than that (Interview 4, Excerpt:4).
>
> Marg: I was on nights and you don't know what goes on during the night.
> I: Those patients are not here now? They've been discharged?
> Marg: That's right.
> I: You may be able to pick up more of an effect or reaction of the patients to the classes if you're working days or evenings following the classes?
> [The investigator thinks there are three shift rotations: 7 a.m. - 3 p.m., 3 p.m. - 11 p.m. and 11 p.m. - 7 a.m.].
> Marg: That's right.
> I: On nights you're not going to get much, they're sleeping while you're on?
> Marg: That's right.
> [The investigator remembers that some nurses are working twelve hour shifts: 7 a.m. - 7 p.m. and 7 p.m. - 7 a.m.].
> I: Nights start at what time?
> Marg: 7:00 p.m.
> I: Would you be able to have some communication with the patients or notice communication between the teaching patients during the evening?
> Marg: Yes (Interview 6, Excerpt:5).

In addition, they were unable to collect feedback from each other about the first program:

> Marg: I didn't know that they (Ann and Beth) hadn't taught. We haven't discussed the teaching program. We get to work and we're just running. Right now the unit is turned around and we're more medical. We've been on call so these patients aren't the chronic ones, we have very few of them. We're focusing far more on the sick patient. We discharged two over-doses yesterday. Our time is spent with everything but chronic patients right now (Interview 6, Excerpt:6).

The nurses could not describe specific reactions of the staff nurses to implementation of the first program:

> Head Nurse: The staff include a comment about the patient teaching program in the report that they give to the next shift. Hopefully, the time will come when all staff will feel comfortable enough to be involved so that any one of them, should there be a change, will be able to step in and present a session (Interview 4, Excerpt:5).
>
> Ann: I have not asked specifically, but I have felt that the program is accepted by the staff, more now than it ever was. Now that it's being run, I don't hear any negative comments about it.
> I: There were a few?
> Ann: Yes. They were skeptical. I did hear skeptical remarks.
> I: Have you heard any positive comments about the program?
> Ann: No, I can't say I have and I guess I haven't really asked or brought the subject up to some of those who were skeptical. If the opportunity arises maybe I will discuss it.
> I: What about at coffeebreaks and in the back room?
> Ann: There would be opportunity to discuss it.
> I: But so far the discussion hasn't naturally flowed that way? Is that what you mean?
> Ann: No, it hasn't (Interview 5, Excerpt:3).

The nurses were not sure that the doctors knew much about implementation of the first program:

> Marg: I don't think the doctors know who's in the teaching program (Interview 6, Excerpt:7).

The nurses had not developed any plans to collect follow-up data from the patients:

> I: Do you have any plans to follow these patients up or do you see that as what I'm here to do?
> Head Nurse: That's one of the things I was hoping that you'd be able to do. That reminds me though that I do have a questionnaire that the staff may be able to use for these patients prior to the program and immediately after. We may be able to capture some impressions from them [the patients]. But, no, that has not been talked about as far as our activities are concerned, not yet (Interview 4, Excerpt:6).

The head nurse identified some expected learner behaviors. She expected certain activities to be discontinued and specific coping mechanisms which had been taught in the lecture to be utilized by the patients:

> I: If I were to ask you now, what kinds of expected outcomes or behaviors you would expect to see in the patients that took that class of yours last week say, three months from now, would you be able to verbalize any of those at this time?
> Head Nurse: In terms of the very practical day-to-day things that affect their lives, yes. I think that it might be possible to identify them theoretically, anyway. The kinds of activities they have dropped from their lives and the specific coping mechanisms they've been using in terms of things that were mentioned in class. It would be interesting to see whether they picked up on the relaxation techniques that we taught, and whether they used them (Interview 4, Excerpt:7).

Finally, the nurses discussed the planning that had occurred prior to implementing the first program and offered suggestions of how that planning could have been improved.

The head nurse reported that she had delivered the lecture as she had planned. However, she thought that changes would be made by the other teaching nurses and that perhaps some meetings could have occurred with all the teaching nurses to develop the modules and the learner activities in more detail. In addition, she pointed out that the nurses were following the format of the old program:

> Head Nurse: I think that I included everything that I felt should be. However, I think when the group goes over the information they may see areas that they feel should be changed. Ideally I think the whole program should be mapped out before it started. What's happening now is that we're sort of backtracking. I think the program should be developed as modules with the activity part of it really quite spelled out. We should have had the exercises that the

> patients were going to be doing complete in the binder so that one could just pull these things out.
> Ideally the group should get together and maybe meet once a week and totally plan the program. On the other hand we're sort of following the format that physio and O.T. have used in terms of areas to present. It may be that as we go along we may find that there are other things that we want to include. In that sense, perhaps this has been a good way to do it. I'm sure that as times goes on, the snags will show themselves, and we'll have to deal with them as they occur. Not only deal with them but come up with a better way of handling it (Interview 4, Excerpt:8).

Ann thought that the nurses should have met for one day, in a location off the unit, to develop the objectives:

> Ann: I suppose it would have been better if we would have been able to take time, set a day aside, and discuss the program and our objectives, work on it away from the unit, get it all together. We were always grabbing an hour here or two hours. It seemed we were always rushed. That probably would be the only recommendation I would make (Interview 5, Excerpt:4).

Marg thought the planning was good. More would have been better, but unrealistic in a hospital setting:

> Marg: I think the planning was good. I think the planning was necessary.
> I: What do you think were the strong points of the planning?
> Marg: Just knowing what we wanted the patients to get out of it, our objective. More planning would have been better, but impossible in a hospital situation.

However, Marg went on to discuss her need to know more about the rehabilitation component of the program.

> Marg: I think we all should have been aware of every class. I think we should know every facet of the program, what they're learning in physio and O.T. as well. The patients are going down to physio. I don't know what's happening there. Wednesday evening they go to physio and perhaps

another evening. It's a bit disjointed. Physio and O.T. know what we're doing. If the whole team had been able to get together, if there had been more time, for a couple of days, to get everybody together, that would have been the ideal but, as I say, impossible.
I: Do you feel a need now to meet with the physio and O.T.?
Marg: I think it would be a good idea.
I: Do you have any suggestions of how that could be handled?
Marg: Probably going with the patient.
I: Every since this unit has been opened that patients have gone to physio and O.T. with porters, is that correct?
Marg: Yes.
I: So in effect, you've lost contact with those two departments? Is that right?
Marg: No, they're on the unit often.
I: With the individual patients?
Marg: Yes.
I: Do you feel that there's an opportunity to have any dialogue with the O.T. and physio to find out what's going on?
Marg: There's just no time because of circumstances on the unit right now.
I: It would seem that you have no idea of what feedback physio and O.T. are getting about the program either at this point.
Marg: Except from the head nurse.
I: So the head nurse is the liaison person?
Marg: Yes (Interview 6, Excerpt:8).

The first program had been implemented. Some tentative conclusions and hypotheses had begun to emerge.

## Conclusions and Tentative Hypotheses About Implementation of the First Program

It has been demonstrated in Chapters 4 and 5 that the investigator, while analyzing the documents and the data and while interviewing the nurses, began to form faint impressions about the implementation of this change. It was while the investigator was interviewing the nurses during and after implementation of the first program and while the investigator was analyzing the data following those interviews that the impressions became more distinct and began to resemble conclusions and hypotheses. The conclusions and hypotheses are listed in Table 6.2. Supporting evidence on which each was based is provided for the reader and can be located in the preceding overview section by referring to the corresponding interview and excerpt number listed in Table 6.2.

It must be stressed that these conclusions and hypotheses were only tentative. They were derived from the data after the implementation of the first program. During the remaining sections and chapters it will be shown that some conclusions and hypotheses were confirmed, while others were not. The conclusions and hypotheses are not discussed in detail at this time for three reasons. First, it is the opinion of the investigator that the data "speaks for itself." Second, the conclusions and hypotheses are only presented at this time so that the reader may be alerted, as was the investigator, to the threads that appeared to be emerging and had potential to become variables or factors which could later be determined to have had a powerful influence on implementation. Finally, the tables are provided now to serve as advance organizers for the detailed discussion, which is provided at the end of the chapter. However, before proceeding to the next section of the chapter, the investigator will explain how the conclusions and hypotheses emerged.

Immediate impressions were formed by the investigator during an interview. The impressions often occurred in response to something the interviewee had just said or something that had been said in a previous interview by the same or a different interviewee. If it was appropriate to do so, the investigator followed up immediately. One

Table 6.2

Tentative Conclusions and Hypotheses which Emerged After Implementation of the First Program
(June 14-June 23, 1983)

| | Conclusions | Evidence | Emerging Hypotheses |
|---|---|---|---|
| 1.1 | The nurses who had taught the first program enjoyed the experience and felt the classes were worthwhile. | Interview 4, Excerpt: 1<br>Interview 6, Excerpt: 1,3 | |
| 1.2 | The nurses who had taught the first program reported that the patients enjoyed the classes and that the patients reported the experience to be worthwhile. | Interview 4, Excerpt: 1,3<br>Interview 6, Excerpt: 1 | |
| 1.3 | The nurses could identify observed learner outcomes. | Interview 5, Excerpt: 1<br>Interview 6, Excerpt: 1<br>Interview 4, Excerpt: 1 | The enjoyment which the nurses experienced appeared to be directly related to the observation of learner outcomes, in particular, the positive reactions of the patients during and after the class and the apparent belief by the patients that the classes were worthwhile. |
| 1.4 | The anxiety level of the nurses decreased after teaching the first class. | Interview 4, Excerpt: 1<br>Interview 6, Excerpt: 1 | Some anxiety about teaching is alleviated after becoming immersed in the act of teaching. |
| 1.5 | The nurses who taught the first program felt they had adequately prepared themselves to give the lecture. | Interview 4, Excerpt: 2<br>Interview 6, Excerpt: 2 | |
| 1.6 | Planning for implementation could have been improved. | Interview 2, Excerpt: 8<br>Interview 4, Excerpt: 8<br>Interview 5, Excerpt: 4 | Planning for implementation had not been a priority to this point in the change process.<br>Some immersion in implementation is necessary before participants can begin to plan for implementation. |

Table 6.2 (Continued)

| | Conclusions | Evidence | Emerging Hypotheses |
|---|---|---|---|
| 1.7 | Two of the four teaching nurses had not developed explicit objectives and content prior to implementation of the first program, but rather had identified some questions, probes and exercises which they used to organize and guide the class in addition to using the material from the 'old' program. | Interview 2, Excerpt: 2,7<br>Interview 6, Excerpt: 2<br>Interview 4, Excerpt: 8 | The teaching program was not a priority of the teaching nurses.<br>The teaching nurses did not know what were the features or components of a teaching program.<br>The teaching nurses did not know how to develop the components of a teaching program.<br>The teaching nurses expected the 'old' program would provide them with enough information to teach the program. |
| 1.8 | The nurses who taught the program expected that the patients would lead the class and would determine the focus which the class would take. | Interview 4, Excerpt: 2<br>Interview 6, Excerpt: 2 | The teaching nurses believed that the learners should determine the focus of the class.<br>The teaching nurses did not know how to focus a class.<br>The teaching program was of low priority. |
| 1.9 | The teaching nurses were not communicating with each other about the program. | Interview 2, Excerpt: 3 | Some of the teaching nurses considered the teaching program to be of low priority. |
| 1.10 | Classes were not conducted according to the original schedule. | Class #3 was cancelled | The original schedule was not important.<br>The original schedule could not be implemented. |
| 1.11 | Seriously ill patients had admitting priority over chronically ill patients on Unit Y. | Interview 6, Excerpt: 6 | Seriously ill patients have admitting priority over chronically ill patients.<br>The teaching program is not of high priority. |
| 1.12 | The work environment was busy, interruption-laden, unpredictable and complex. | Interview 2, Excerpt: 4<br>Interview 6, Excerpt: 1,6,8 | The work environment contributed to changes in the programming schedule and to difficulties which the nurses encountered in trying to communicate with each other. |

Table 6.2 (Continued)

| | Conclusions | Evidence | Emerging Hypotheses |
|---|---|---|---|
| 1.13 | The teaching nurses rotated at different times through different shifts so that all four plus the head nurse never worked the same shift at the same time. | Interview 2, Excerpt: 4,6<br>Interview 4, Excerpt: 4<br>Interview 6, Excerpt: 5 | The staffing patterns and patient assignment patterns for the nurses contributed to the lack of communication among the teaching nurses, between staff nurses and the teaching nurses, and between the teaching nurses and the teaching patients. |
| 1.14 | The teaching nurses were not necessarily assigned to nurse their teaching patients. | Interview 2, Excerpt: 6 | |
| 1.15 | The teaching nurses were not soliciting feedback from each other, from the patients, from the doctors, from the staff nurses, and/or from the rehabilitation (physio and O.T.) department. | Interview 4, Excerpt: 4,5<br>Interview 6, Excerpt: 6,7,8<br>Interview 5, Excerpt: 3 | Collecting feedback was not considered a priority during program implementation. |
| 1.16 | The teaching nurses had not identified prior to implementation what feedback to collect or from whom. | Interview 4, Excerpt: 6,7<br>Interview 6, Excerpt: 6 | The teaching nurses did not see a need to solicit feedback.<br>The teaching nurses did not know how to solicit feedback. |
| 1.17 | Patients were discharged after the last class. | Interview 5, Excerpt: 1<br>Interview 6, Excerpt: 5 | Program format contributed to lack of opportunity to solicit feedback about the program.<br>Collecting feedback from patients is not a priority. |
| 1.18 | The teaching nurses had not identified expected learner outcomes prior to teaching the class. | Interview 2, Excerpt: 12<br>Interview 4, Excerpt: 7 | The teaching nurses saw no need to identify expected learner outcomes prior to implementation.<br>The teaching nurses did not know how to identify expected learner outcomes. |
| 1.19 | Changes in program development and delivery were occurring and being suggested by the teaching nurses. | Interview 2, Excerpt: 1,8,10<br>Interview 4, Excerpt: 6,8 | The program as planned or unplanned was not meeting current needs of the teaching nurses. |

Table 6.2 (Continued)

| | Conclusions | Evidence | Emerging Hypotheses |
|---|---|---|---|
| 1.20 | One nurse reported lack of support and a need for guidance | Interview 2, Excerpt: 9 | The teaching nurses were not receiving guidance and support. |
| 1.21 | One teaching nurse needed to know about the other departments involved in the program. | Interview 6, Excerpt: 8 | There is no coordination between the teaching program and other departments.<br>The teaching nurses are not communicating with other departments.<br>The program may have a multidisciplinary focus rather than only a nursing focus. |

example worth noting is Interview 5, Excerpt 6. The investigator wondered, based on what Marg said about "not knowing what goes on during the night" and the previous response of the head nurse (Interview 4, Excerpt:4) to a question about obtaining patient feedback, whether the nurses were soliciting feedback from the patients who had attended the lectures. That impression became a conclusion when Marg confirmed that there in fact was an opportunity during the evenings after 7 p.m. to communicate with the patients but that she had not done so.

If it was not appropriate to follow-up on the impression immediately, the investigator would wait and do so later in the interview. One example is somewhat illuminating. The seed for the impression about patient feedback, which eventually became a conclusion and generated some tentative hypotheses, was sown in Interview 4, Excerpt 4, with the head nurse. Emerging from that excerpt were three leads which the investigator wanted to follow up. Why had feedback not been solicited from the patients immediately after the lecture? What feedback was solicited from the teaching nurses? What feedback was solicited from the staff nurses? The investigator chose to follow the lead about staff nurses and later in the interview asked a responsive question about soliciting feedback from the patients. The response to the question appears in Interview 6, Excerpts 6 and 7, where it became clear to the investigator that plans had not been made by the nurses to solicit feedback from or to follow-up the patients who had participated in the program. The impression had now become a conclusion. In addition, the tentative hypothesis emerged about whether the nurses knew how to or from whom to solicit follow-up data or feed-back.

If the investigator could not return to the topic to check out an impression during the same interview, the impression was noted in the field notes. If a conclusion or tentative hypothesis had emerged, that also was noted in the field notes. Not all of the listed conclusions and tentative hypotheses emerged during the interview. Often, the investigator would form an impression while driving back to the office from an interview. The impression would be noted on a sheet of paper to be inserted into the field notes. Occasionally, impressions would be formed while the investigator was involved in other activities. Again, notes were made on whatever was available (matchbooks, serviettes, paper towels, telephone pads) to be later filed in the field notes. The investigator was gently reminded of the importance of continuing to be sensitive to these impressions and to continue drawing conclusions and developing tentative hypotheses by her supervisor who during debriefing sessions would consistently ask, "Did you make a note of that?".

Implementation of the Second Program (August 23 - September 1, 1983).

The head nurse, at the conclusion of Interview 4, told the investigator that she had resigned to accept a position at another institution. She, with the approval of the director, chose a staff nurse from unit Y to assume the position of acting head nurse and appointed Ann to be in charge of the teaching program. During a two week period in early August, the acting head nurse was oriented by the head nurse. On August 12, the head nurse left the unit. The acting head nurse went on holidays August 22 and returned to the unit on September 6.

The second program was taught from August 23 to September 1, 1983, by Ann, Beth, and Ruth, the three nurses who had not taught in the first program. Ann taught the first class (the film) as scheduled on Tuesday evening of the first week and had planned to give the lecture on stress on Thursday of the same week. However, on Thursday evening she was 'pulled' from unit Y to help on another unit and therefore did not teach about stress until Wednesday of the next week. The original program format (Chapter 4, Figure 4.1) had indicated that a pharmacist would give a lecture about medications on Wednesday evening of the second week. However, the pharmacist was on holidays and could not teach. Ruth was working the 7 p.m. - 7 a.m. rotation during the second week, so with one day notice, volunteered to give the pharmacy lecture on Tuesday evening of the second week. Beth had planned to give the lecture on quackery (which was originally scheduled for Thursday of the second week) on Wednesday of the first week. However, when she went to the classroom, the physiotherapist was in the process of teaching a scheduled class. Therefore, Beth returned to the unit after a 7 a.m. - 3 p.m. shift on Tuesday of the second week (the same night as Ruth was to give the lecture on medications) to teach about quackery. A lecture on community resources had been scheduled to be taught on Monday of the second week. However, the woman from the social services department was on holidays. The class was cancelled.

In comparison with the planned schedule the actual schedule for classes taught during the second program now looked like Figure 6.1.

Two of the three nurses taught a class on their own time. Beth had worked from 7 a.m. to 3 p.m. and came back after work to teach her class. Ruth was on the 7 p.m. to 7 a.m. shift and left the unit to give her lecture. Ann came back to the unit while on a day off to teach her first class and stayed after a 7 a.m. to 7 p.m. shift to teach her second class.

Two of the three nurses were on the unit the day after they taught. Ann and Ruth worked a shift on the day following the class they taught. Beth was on a day off following her class. The final lecture of the second program was given Wednesday evening. The patients were discharged on Friday of the same week.

Report of Ann, Beth and Ruth about implementation of second program. Ann thought that implementation of the second program had been a positive experience:

> Ann: It's been a positive thing and nursing has had a good role to play. I think all the girls feel good about it (Interview 7, Excerpt:1).

Some changes were made in the program delivery during implementation of this second program. The classes were re-ordered, one class was cancelled and one extra class was taught by the nurses:

> Ann: We should have had the stress class last Thursday and we couldn't work it in. So we combined the quackery and the pharmacy classes. The pharmacist who was looking after that lecture has been on holidays, so we taught that. Ruth taught it and had no problem. The only thing missed out was the community resources class. The social services department hadn't chosen somebody else to do the lecture, the girl had gone on holidays, and we had nothing in our manual about

Week 1

| | Mon. | Tues. | Wed. | Thurs. | Fri. |
|---|---|---|---|---|---|
| Planned | | Film | Physio | Stress | |
| Actual | | Film | Physio | | |

Week 2

| | Mon. | Tues. | Wed. | Thurs. | Fri. |
|---|---|---|---|---|---|
| Planned | Community Resources | Physio | Pharmacy | Quackery | |
| Actual | Community Resources (cancelled) | Quackery<br>Pharmacy | Stress | | |

**Figure 6.1**

Comparison of Planned Program Schedule
With Actual Schedule For Second Program

> community resources. We feel bad about that. It was short notice to get anything together (Interview 7, Excerpt:2).

According to Ann the nurses had allowed patients who did not meet the "criteria for selection" to attend the sessions which resulted in a "tiff" with the physiotherapist. The nurses disagreed with the criteria which had been established by the physiotherapy department and felt that the two departments should establish separate criteria for selection of patients for the program:

> Ann: Nursing did something a little different this time. We invited other patients into that first lecture. That was a positive thing. The ones who had not been chosen for the program thanked me after. They are going to come to-night to the stress session. This is something that we would like to continue. We've had a bit of a "tiff" with physio about that. They felt that they had the criteria and we should follow the criteria, that a lot of these patients were not capable of learning. We thought that their criteria was a bit strict. We said "Nursing can't really follow something like that, because we feel that even though they [patients] don't get as much out of it, who are we to say that they are not going to benefit?" We feel that's the philosophy of nursing. They should be there if they want to come. That's something that we will probably continue to do - to go around and invite those who had related diseases.
>
> In my discussion with the physiotherapists, I said, "I almost see two groups of people who need to be taught". I said, "If you don't feel you can open your physio classes up to more than those you've chosen, then perhaps we need another group". Afterwards I thought, "They can carry on their physio classes for whoever they feel they can help and we can have our lectures here on the unit." There's no reason why we can't invite others in.
>
> We need separate criteria for the nursing lectures and some broader objectives that would cover more people. Physio stipulated that the people must speak fluent English, that they must not be hard of hearing, that they can sit for an hour without being uncomfortable, that they show a real desire to learn, and that they be newly diagnosed.
>
> There are patients who came to the film and said, "We saw a film before when we were here." After the film they said, "That was a different film." They enjoyed seeing this one and I don't see any harm in their sitting through it again

(Interview 7, Excerpt:3).

Beth did not view the implementation of the second program, and her first time teaching a class, in quite the same positive light as had Ann. She felt unprepared and felt that her class had been disorganized:

> Beth: I wasn't fully prepared because it's been a while. I went over the materials a few times, thought about what I was going to say, but I wasn't quite sure. I didn't have a clear format. There were four patients, plus we invited another patient along that physio wouldn't include in the program that we thought needed it. She was very happy to come. A husband of one of the other patients came and we had good discussions. I let them lead me a little too much but I thought it was best. It made me feel more comfortable. We covered most of the information. Now I know how to organize myself a little better and how to keep things on track. They could discuss things forever. I think it could have been better organized (Interview 8, Excerpt:1).

Beth identified ways to improve her class:

> I: Do you have an idea now about what kinds of things you will do before you teach your next class?
> Beth: Yes, I'm going to sit down and write out an agenda, an outline that I'll either give to them before or write on the board and run through before we start. I think that will work better. It's a nice sized group to talk to and the patients are very open, very receptive. All of them seem quite interested. There are some that aren't as willing to learn, they'll sit and listen to the lecture, but you know they're not absorbing. Those are the ones who will probably have to repeat, the ones we should keep track of and get back to again. They'll probably be coming back in again, because they're not taking care of themselves as well as the others who are willing to learn (Interview 8, Excerpt:2).

She felt better after having taught her first class than she had before teaching it. However, she still felt that it had been a disorganized program. The disorganization was related to schedules of the teaching nurses, the change in unit leadership, and to one particular incident with the physiotherapist over criteria for selection of patients for entry to the program. Beth had little knowledge about the history of the program adoption:

> Beth: I feel better about it now that I have done it. I didn't want to do it anymore. It was bothering me having to stay over or having to come back in. I felt it was an imposition. This time, it was very disorganized as far as determining times for lectures, because we were just told [by the acting head nurse] of all of a sudden, "We're going to do it this week. Let's get it ready." We thought, "All right, fine". We were trying to figure out what days would be best for us according to our schedules, not according to the schedule that we'd planned, like the regular Tuesday, Thursday. We hadn't realized that physio was doing a lecture one evening, I think it was a Wednesday evening. I walked in and . . . I'll start from the beginning. Ann did the introductory lecture. She invited some of the other patients that weren't scheduled. They all were patients with [the ~~chronic~~ illness]. They all were very impressed with the film and very enthusiastic and happy to be there. We thought some of these people needed to see this film and to be part of the program. Well, the next time, I was going to do quackery. I walked in, and physio had planned to do a lecture that night. The physiotherapist was very rude to me in front of the patients. She told me that she didn't think it was right that we had let the other patients attend the lecture. I didn't think this was right to talk about this in front of the other patients. After the lecture, Ann talked to her and asked her what her criteria were for having patients in the program. We thought we had input about who should be in and who shouldn't. The physiotherapist told us that it was physio and O.T. who decide who is in and who is not in. This was news to us. She told us that physio has very strict criteria. The patients must speak English, must not be hard of hearing, must be able, capable and willing to learn. Ann said, "Have you got a way of testing all those things?" She said, "No, but we know". We're very upset, it started off badly. I said "I don't even want to do this". I didn't, not unless we know what is going on. They [physio] decided that only three or four people can use it and we think that there are six or seven who could benefit.
> The acting head nurse talked to physio and they decided that they had enough patients to go ahead. It was physio who decided who the patients were going to be. It didn't seem to be the doctors or the nurses. We've decided to take matters

> into our own hands. Ann had talked to the head nurse before she left. The head nurse had said "No, it is us who should be deciding". We're going to talk to the doctors to get it clear about what should be happening. Something should be done or decided.
> We've started off with some bad feelings, lack of communication between our department and theirs. We need that communication. Ann was very diplomatic, I think, in talking to them. She is going to try to keep the lines of communication open. We don't want to alienate them. We need them. They are the majority of the program. It has been a little difficult, I think that was probably the problem from the very beginning, which we had known nothing about. We weren't aware (Interview 8, Excerpt:3).

Ruth taught the pharmacy lecture during this second program. It was the first class she had taught in the program. It was a lecture which the nurses had not been scheduled to give. She tried to prepare for the class and felt good about it afterwards:

> Ruth: It was fun; it was good. I enjoyed it. My reaction when I knew I was going to give it was one of sheer panic. I thought, "My God! You give these pills out every day. You know their basic uses and their side effects. But can you teach it?" I thought to myself, "Can I tell them and make them understand why they should take them and when they should take them?" I learned a lot getting that lecture ready. I had their [pharmacy] information that was in the old teaching manual. I worked madly all night long going through the old manual and sat there with the drug book and studied all those drugs. Some of these drugs are so new. One drug was new. I knew there had been an handout brought up from pharmacy on it. I went through that whole nursing station, absolutely everywhere in the station to find the handout. It wasn't there. I had to get it the next night before the lecture. I phoned pharmacy when I came in. But I didn't have a lot of information on that drug.
> Afterwards one of the girls said, "It looks like you're going to school." I said, "I feel like it." On the night of the class, we did our paper work up in next to no time. I sat between patient rounds and just skimmed through everything. I learned a lot. I felt fairly comfortable when I came in to work that night. Did you know that it takes three weeks to get the full effect of [drug Z] alone? I didn't know that until I started to read (Interview 9, Excerpt:1).

Ruth explained *how she taught the class* and what the *reactions of the patients* were like:

> Ruth: We taught quackery and pharmacy on the same night. I went in after Beth taught quackery. I didn't hear her class on quackery. I let them get up and walk around and stretch and get a cup of coffee. Then I taught. I had written their [the patients'] meds down so that I could question them about their *own* meds, the ones that they were on right now. I sat down and introduced myself. I said, "I don't know if you know who I am." We sat there for a few minutes and talked a bit about the quackery lecture. I had worked with most of the ladies and some of them were my own patients. I took my pills and injectables and put them out on the coffee table. I gave them a handout and we went through that. I had a pocketful of pens in case they wanted to write anything done. Then I discussed the pills. They wanted to see the pills and feel them. The biggest thing was to explain why the pill they take at home looks different from the same medication they take here in the hospital. They had a lot of questions relating to their own medications. Would this interfere? Would that interfere? Some of the questions I could answer. Some of them I said "should be checked out with your doctor". I didn't know where there was a quick source where I could find something. I said, "If you are taking any medications, check with the doctor first" (Interview 9, Excerpt:2).

Ruth explained why she had been able to teach the pharmacy class on such short notice. She had previously attended the complete old program on her own time, she had some teaching experience, and she had some oratory experience:

> Ruth: I had gone on my own a year ago and sat in on the old program, when physio were giving it. I haven't seen anything since. I taught before. I only taught people who were coming in off the street to work in a nursing home. I haven't done that for seven years. Also, I have a lot of oratory experience. I did that all through school, I've been in competitions (Interview 9, Excerpt:3).

Ruth reported that it was *difficult to gain feedback* from the patients because they were discharged after the last lecture:

> Ruth: I wish that the pharmacy lecture was given the first week. They were only here a day and half after the class. I only had Thursday and they were out by Friday afternoon (Interview 9, Excerpt:4).

Ruth was disturbed, as Beth had been, about the developing problem with the physiotherapy department over the criteria for patient selection. She felt that nursing had better control of the program when the former head nurse had been on the unit:

> Ruth: There's big hub-bub with physio over this program. There's been problems since [the former head nurse] left. The extra patients, who weren't in the program, went into the class and [the physiotherapist] blew her cool, because [the physiotherapist] thought she had control of the program. [The former head nurse] would say "This is not your jurisdiction." Ann is doing that now, which is good.
> I: When [the former head nurse] was here did you have a feeling that you did have control of the program?
> Ruth: We had better control (Interview 9, Excerpt:5).

The nurses had allowed three newly admitted patients with a related chronic illness, who had not been assessed by the physiotherapy department, to attend the nursing classes. Ruth explained the reason for doing this and the reaction of the physiotherapist:

> Ruth: The physiotherapist was going to have the program this week. She was only going to allow the three patients she had assessed into the program. She happened to talk to me that day. I said "We've got these three people who have just come in." She said, "Well, I haven't assessed them." I said, "I feel that they need the program." I told her what each of their needs were. I said, "Look, why keep these other people waiting, they are in here, why keep them another two weeks to run the program again?" She said, "O.K., we'll let them go into the program and I'll see them Monday in pool. Then

> we'll decide whether they should go to the film on Tuesday." I said, "They can go to any of our lectures. Anyone on the ward can. I don't care if they've got a related or unrelated illness. If they want to see that film they are more than welcome to come when nursing is giving it."
> I: What happened?
> Ruth: She said, "We'll only have the ones from the program for our section." I said, "I feel that's a little unfair. We're doing education. Until that's been clarified with everybody then that's fine."
> I: What is happening now?
> Ruth: The whole six are going.
> I: Did they get assessed on Monday?
> Ruth: Oh, I guess, I wasn't there. They're still in the program, so they must have (Interview 9, Excerpt:6).

However, Ruth was more disturbed over the changes which she reported were occurring on the unit since the former head nurse had left. A summary of the contents of Ruth's discussion is presented below. Seriously ill patients were being admitted to the unit now, who in the opinion of Ruth would have not been admitted or would have been transferred to another unit sooner had the former head nurse been there. Orders for patients were not coming through quickly enough. The desk work was sloppy. In Ruth's opinion, the position of acting head nurse had "gone to the staff nurse's head". The acting head nurse would not answer the phone and would not do "hands on patient care" when the work load was heavy. Communication between staff had broken down as the nurses wondered who would eventually become the permanent head nurse. Two separate "cliques" of nurses had always existed in relation to the rotation pattern. The "cliqueness" was becoming worse. The acting head nurse was "brown-nosing" the doctors and Ruth feared that the professional status for nursing which the former head nurse had worked hard to establish was in jeopardy. She feared the nurses would again become "maids" to the doctors. The former head nurse had been able to "curtail" and deal effectively with the control which the physiotherapist sought over the program. Ruth did not see the acting head nurse taking the same strong position. The committee system and the ward meetings which the former head nurse had established to make unit decisions had been abolished. Decisions were now made about who would do which activities, ie: take Christmas holidays and give a presentation at Grand Rounds, by drawing names of the nurses out of a hat. The coffee kitty had been abolished. Ruth was upset with the way the acting head nurse had been chosen. The staff were not consulted, which was the usual pattern in this hopsital. She did not know who had made the decision or when it was made. And to add fuel to the fire, no announcement was made, but rather a memo appeared on the bulletin board one week after the acting head nurse had assumed the position. In addition, although the acting head nurse had many years of experience, she had just recently received her R.N. This, according to Ruth, was unfair to the acting head nurse and unfair to the rest of the staff nurses.

Ruth was fed up, she'd had enough, and she was going to resign. Too many changes had occurred and the unit was not meeting her expectations:

> Ruth: Needless to say I'm going to get the hell out. I'm only here till December. I don't want to work in a place that's disgruntled. Communications are poor. A lot of things have changed over night. A lot of unrest. I thought this was going to be a great challenge. I thought there was to be more than just basics. I love to work with patients. I love bedside nursing. I thought there were going to be a lot of other things to do and time off to do it. There

> hasn't been anything. Sure, the budget was the number one problem. O.K. we had to do something about it. But nothing has been done since things opened up. This hospital is as full as of staff as it ever was. Nothing changed. You know I think the best solution in the place is a change in the staff. The ones that are happy should stay. The ones that are restless should go. We've been too patient too long. I need to get away this week, got to get away tonight (Interview 9, Excerpt:7).

Ann's plans for program development and delivery. Ann, as nurse in charge of the teaching program, discussed the needs for program development and delivery which she had identified after teaching her first program. Each teaching nurse should be prepared to give each lecture:

> Ann: The girls feel more confident. [The former head nurse] left me in charge of the teaching part. I'd like to rotate the girls through [each class] so they feel confident in giving all the lectures. Then whoever is available can teach the class. I think we will try to work towards that goal (Interview 7, Excerpt:4).

A meeting should be held among the teaching nurses and between the teaching nurses and the other departments involved in the program:

> Ann: We're going to have a meeting when [the acting head nurse] comes back and hopefully with physio and O.T. and pharmacy (Interview 7, Excerpt:5).

A system of record keeping should be established:

> Ann: These are things I see a need for. To establish a system of record keeping. I don't see anything formally being done right now. I'd like to start that, try to get the names and even addresses in case we want to do a follow-up. Then we'd know exactly who has been coming to the program and we'd have a history about their disease and how long they've had it. We have some records, nothing really accurate, now. Also, it's another way of establishing a record for the

Association (Interview 7, Excerpt:6).

The patients should receive a booklet to take home:

> Ann: The Association said that they would fund printing a booklet to hand to the patients that they could take home with them. The patients get a lot of pamphlets and handouts. We should be putting that together in one booklet. There would be a section on rest and activity, a section on exercise, and a section on medication that they could refer to when they go home. They would say, "Oh yes, I remember being taught that. How do I take my medication?" We have to work on that. That will come up in the meeting (Interview 7, Excerpt:7).

Teaching modules should be developed:

> Ann: The next thing, and it will take a long time, is developing a manual of the modules for teaching. I've been looking through the teaching program at [another hospital] for [another disease]. They have a fantastic program going. They worked two years on developing their teaching modules. They're beautifully written. They use them all the time. It ensures a standard of teaching. Whoever is teaching the patients will just grab the manual and follow it. Then you know that the patients are being taught what has been set out. We are developing our own but we haven't finished. We're working on it. Beth teaches the class one day and then I do it the next day. Who's to say that we're teaching the same? It's going to be a big job. I think it's necessary to work on it now. I see probably half a dozen that we need to write. If physio, O.T., pharmacy, and community resources would consider writing their modules. There are quite a few I think that could be written (Interview 7, Excerpt:8).

Funding and development time should be provided to develop the modules:

> Ann: If everybody is agreeable, I will even approach the Association for a little more money so some of us can spend a whole eight hour day developing the manual and printing it up.
> I: I hear you saying that you're feeling the need to have some time to sit down and plan, develop and write?
> Ann: Yes, it's almost impossible to take time off this

ward. The nursing office is not sympathetic at all. One night I was going to teach, we were busy, and they pulled me to go to another ward from 7:00 to 11:00. They wouldn't change it.
I: What happened to the teaching?
Ann: We left it to this week. We know now that we can't book anybody to teach who is on duty. That means we have to stay after a 12-hour day or come back on our days off.
I: What do the rest of the team think of that?
Ann: Ruth is willing to do it. She doesn't mind. Beth is more enthusiastic about it now as she gets a little more into it. Marg is quite tired when she's finished her 12-hour shift. She wants to go home. She doesn't feel free enough to stay. She says, "I have a life of my own." She's not keen about coming back from days off. Maybe she'll help in other ways (Interview 7, Excerpt:9).

An evaluation system should be developed:

Ann: We'll have to have evaluation. Hopefully we'll establish something. In these modules, I would like to develop pretests and posttests for teaching. I feel that it's necessary, I don't know how to go about it. It's something we'll have to work on, to see just how much learning actually does take place (Interview 7, Excerpt:10).

Expert help would be required:

Ann: Physio did a pretest and a posttest for a few months. Then they decided to drop it because they felt they weren't getting the right answers from the patients. Whether or not their questions were not good questions, they just felt that the answers were not accurate. I think we are going to ask for help, to develop some of these things. We're not experts. I think that there is help available through the research department here or outside (Interview 7, Excerpt:11).

Other teaching programs and resources should be examined and utilized:

Ann: I'm hoping that if the committee agrees I would write a letter to the Registrar at the [other hospital] asking permission to bring one of the copies of the teaching program here to let the committee see what I'm talking about,

> especially the modules. I could of had it done by the time we meet. I didn't think I should push forward and do that without permission. I've been to the [Professional Association] library getting books on patient education. I haven't been able to find anything on pretests and posttests. There is nothing on [this disease], would you believe? There isn't a teaching program written for these patients. There are all kinds of [other programs] that have been around for about three decades, but nothing on [this disease] (Interview 7, Excerpt:12).

Ann discussed what had influenced her to form these plans. Implementation of the two programs, the old teaching manual, her previous experience with a similar program at another hospital, and her baccalaureate education were identified as influencing factors:

> Ann: The ideas became focused in my mind from the program that has been going on and as I read through the manual (I hadn't read through the manual thoroughly before) and realized what had taken place and how things had been planned. That's when I saw the need to focus first of all on record keeping and then on the developing modules. We have to standardize the teaching. I think another thing that made me focus on these ideas was being at [other hospital]. I worked there part-time. I went through their teaching program manual. When I saw it in print I thought, "That is exactly what I've been thinking." I've been talking modules in the teaching program right from the beginning, but I didn't know exactly what would go into the modules. I kept saying, in my mind and to the head nurse, "Now we ought to have things written down in sections so that any of us can grab a module and go and teach it and be sure that we teach the same thing each time." I didn't know how I would ever go about doing this. Now it's coming clearer to me (Interview 7, Excerpt:13).

While examining the teaching program of the other hospital, Ann recognized similarities among the patients in the programs at the two hospitals. She attributed the similarities to the fact that both sets of patients had a chronic though different illness and were in the middle to older age category:

> Ann: The objectives that they wrote out, made me realize that their patients are a lot like our patients, about the same age group.
> I: You're talking about chronic illness and long-term illness?
> Ann: Yes, and different qualities in learning, and middle age and the older patient and then a few younger (Interview 7, Excerpt:14).

Ann discussed what the role of the head nurse during implementation had been. The head nurse had a number of similar projects on the go, was busy, had initiated the change, and had established the contact with the Association:

> I: Did you feel that your ideas were being accepted by the head nurse at the time?
> Ann: Oh, yes. But she was busy with a lot of other things. She agreed to write the objectives. It's a tremendous amount of work and I'm not sure that she ever wanted to put that much work into it because, you know, she was doing a number of other similar things. She did what she set out to do. That was to get the program started. I think she's done a good job. She really had the contacts with the people to promote the program and give us permission to do it. She had contacts with the Association and she was the person who was good at doing that (Interview 7, Excerpt:15).

The three nurses talked about how program implementation was proceeding since the head nurse had left. Ann thought that the other teaching nurses had accepted her appointment to be in charge of the program:

> Ann: I think they've accepted me going ahead with planning and taking over. I don't think there have been any hard feelings. If any of them wanted to do it, they could have (Interview 7, Excerpt:16).

Beth mentioned the effects on herself of Ann being in charge of the program. She was becoming a bit more enthused, Ann was motivating her. Beth was also motivated by the fact that the program finally got started:

> Beth: I think that Ann has more time to spend getting this program refined. She's very enthusiastic about it. [The head nurse] was also. This was her big thing and she did get it underway. But Ann has taken over with enthusiasm. She's trying to motivate the rest of us. [The head nurse] never had the same time for that. It was only one of her jobs. Ann's got me more enthusiastic. She'll call me at home, and she will talk about it. She'll talk to me at work about it, and get me feeling more part of it. I don't think it's just because of Ann though, I think it's because things got started. We finally did it (Interview 8, Excerpt:4).

Ruth was pleased that Ann was in charge of the program because Ann was genuinely interested in the program. Ruth wonder if Ann might like to become the teaching nurse:

> Ruth: I think it's good because Ann is genuinely interested in the program. She wants to see this program work. I think that she would almost like to co-ordinate it, to make it like a clinical job (Interview 9, Excerpt:6).

Beth's plans for program development and delivery. Beth identified the need for a nursing assessment of the patients, the need for co-ordination between the teaching nurses and other departments (including the doctors) and agencies, and a possible need for one teaching nurse to provide continuity of program delivery:

> Beth: We need to do an assessment of these patients, and some kind of social assessment of the family situation. We could use some kind of criteria like the amount of time a husband comes in and offers to help. How much the husband appears to understand? How many children at home? What their income is? Whether she has to work. We could start with that initial assessment and then over time, if we see them again, we could see if the husband is still unable to help with certain things, like the chores. They cover that

in quite a bit of detail in the stress lecture. They really discuss their activities of daily living and how they cope. In the physio lectures, they also discuss that sort of thing. So the patient knows how to react to situations. I think that's very possible that they could list what they do in a day, and what they're doing about things. Then over time we could see if they changed. You see most of the time we can always tell what the family situation is like. We're around the patients all the time. We see how they interact with their spouses and children. We find out the family history. Even if they're in here for only three weeks you get to know them pretty well. You get to know who's having a hard time at home and who isn't, who has support and who doesn't, who has money, who doesn't. That's why it makes me mad with physio, we think we know who can benefit from some of these and they don't feel that we do. They don't know. With some of these patients their biggest problem is the family. From what I've seen there's a variety of contact with social services. There's some patients that know all the organizations, and I don't know how they came in contact with these organizations. In group discussions, one person will say, "Home Care has come in and helped me." Another will say, "What is Home Care?" They've never heard of it before, and they are the ones who probably need it even more. We've also had a lot of problems with people who don't have money. An awful lot of patients. There's not much that I know myself about what's available for them. That's another problem, we need to get more information and get ourselves co-ordinated with the community. That's why we were wondering if we should have a teaching nurse. Even if she was just part-time. It might be hard to do. There's another thing, there's a lot of patients that attend the clinics, the clinics that the doctors have here in the hospital and around the province. Some of these patients we don't see. We want to find a way of getting communication going so we know which patients coming into the clinics could attend the program here.

So far there hasn't been any communication between us and the doctors about those. This is one thing that [the acting head nurse] is going to talk to them about. We want to find out if there's a way that they will communicate with us or if we have to find a way to go between the clinic and here. There has to be a way, because the classes are very small, and we could have a lot more people in them.

I: It sounds like you're saying that maybe at this time, the doctors haven't realized the potential of this kind of program?

Beth: I think so, I really do.

I: Who runs their clinics? Do they run them themselves or do they have nurses that do some teaching in the clinics?

Beth: We don't even know. I don't think that they have

> nurses in the clinics as much as just secretaries who help them get the patients through and do some of the paper work (Interview 8, Excerpt:5).

Reaction to planning for implementation. The nurses discussed the planning that had taken place prior to implementation of the program. Ann thought that these programs had to move at their own speed, that she was better able to write modules after having taught in the program, that a day of planning would have been helpful, and that an evaluation of the patients should be done:

> Ann: I think all these programs have to go at their own speed. I don't know if I would suggest anything more. I can see that sometimes you can't turn the wheels of bureaucracy any faster. I'm sure that we missed a lot of patients in those months. Somehow we didn't work at it fast enough. I think we should have perhaps sat down for a whole day and written out at least the nursing lectures. But it wasn't done and we can't feel bad about that. There are patients that we lost. They didn't get in on the teaching program. As we begin to teach I think that we do a better job of writing. Even just the one session I've had with the patients was so encouraging to me. I feel confident. I would like to do an evaluation on the first 50 patients to find out exactly what they would like to be taught. Then we would probably come up with some very good ideas for writing the modules (Interview 7, Excerpt:17).

Beth thought that many of the problems were due to poor planning and a lack of knowledge on the part of the nurses about program adoption:

> Beth: I think we should have done things differently. We have problems with communications. We weren't even aware of the Association. We weren't even aware of the politics of the whole program, how it was set up, who we were supposed to relate to. Like the Association, they're a very big part of this. They want to attend the lectures. They want feedback about things. We only have funding for a certain period of time and then we have to show them what we need for the next

> amount of time. We didn't know that, I didn't have any idea. There are a lot of patients that have come through the unit. I think we could have got programs set up for them. I don't know if it was just because of physio, or us, or both, but those patients didn't get the program. I think that we should have had time to sit down, take a few days in a period of a few weeks, and spend the whole day, all of us together, sitting and talking and organizing and getting everything written up, doing a bit of research and putting a manual together. We've been putting page by page, scattering things over a period of months. We forget what we were talking about, we forget what we had decided to do. We lose motivation and enthusiasm. If we had done it all within a two week period, because that's all it would have taken to set up the initial part of the manual that we needed to start the lectures. I think if we could have got going, we would have felt good. Then later on after we tried one or two sessions, we would have had the feedback to put the module together properly. We would have had everything properly typed out, handouts that we wanted to give the patients and ways of testing patient reactions. I think you have to do it in a concentrated period of time and organize it properly. You don't have a meeting with three or four of you and then the next time with two of you and have it once a month (Interview 8, Excerpt:6).

Ruth reported that the planning time had not been structured and had been poorly utilized:

> Ruth: We had enough time to plan, we didn't utilize it. It should have been more structured. We had the money to go ahead. We just had two mini-sessions for planning (Interview 9, Excerpt:9).

Communication among the teaching nurses. The nurses discussed how they had been communicating with each other. Beth reported that though the nurses were talking about the program more, they still did not meet as a group:

> I: It sounds like good ideas are coming out after this second program?
> Beth: I think so, but we have been talking about it more. We had stopped talking.

> I: How have you been talking about it? Have you had a meeting? How has it been happening?
> Beth: No, we haven't had a meeting. It's been hit and miss on the floor. Ann had made a point of calling me at home so that has been specific and planned. Otherwise talking with one or two at a time and passing information on to each other. One day we tried to have a meeting between Marg, Ruth, and myself. We wanted to look over the manual and get ourselves together. We never got together. We couldn't the way our schedules were. One girl was coming off nights. It was the day off for two of us and we each had made plans. We called each other. One girl wasn't home. It was a mess (Interview 8, Excerpt:7).

While Ann and Beth talked with each other, Ruth and Marg did not:

> Ruth: I don't know what's going on with Marg. I never work with Marg (Interview 9, Excerpt:10).

Motivation/commitment of the teaching nurses. The three nurses discussed their commitment and motivation to the program. Ann thought that Ruth and herself were the most committed:

> Ann: I've been pleased that they want to continue, especially Ruth. I think Ruth and I feel probably the most strongly committed and Marg and Beth to a lesser degree (Interview 7, Excerpt:18).

Beth was motivated by patient feedback and concerned about compensation:

> Beth: I think I need patient feedback. Otherwise I wouldn't feel it was worth it. I was talking about this with Ann. I think that Marg would feel better if she was paid for the time when we had to come in for meetings. I sort of feel that way myself a bit. I don't mind meeting on the floor, getting together once in a while informally. But to really get work done, you have to have a specific time set. Not everybody will come (face it) if they aren't going to be paid. You only have two days off in that week. They aren't going to want to. Ann was going to see if funding would cover for us to get together and spend some time. I think

> it's necessary. Otherwise, you don't feel like you're doing a professional job (Interview 8, Excerpt:8).

Ruth was motivated by the patients and herself:

> Ruth: I do this for my own satisfaction. I wouldn't do it to make this ward look glorious, I'll tell the world. My heart is not in it as far as this ward is concerned. I would do it if it was a necessity for the patients, but I would not do it for anybody else (Interview 9, Excerpt:11).

Observed learner outcomes. Ann and Beth discussed the patient behaviors they had observed during and after the class. They could identify changes in patient behaviors but Beth did not know how to measure them:

> Ann: The patients come back to us and really show their appreciation. They said everybody should go through the program. They learn so much. I had a good talk with one of my patients this morning who's in the teaching program. She thanked me for our contribution, for our part in the program and she said, "I learned so much." She said, "My husband is a doctor, but you teach things in such a way that I understand them. All the medications that I learned about last night came clear to me. I know now that I'm going to be very careful, that I can help myself." I thought, "That's good." That's what she should be learning and that's what we like to hear (Interview 7, Excerpt:19).

> Beth: I would say from talking to them on the floor and after I'd left the lecture (and knew I wasn't going to see some of them before they were discharged) that they were quite enthusiastic. They were very attentive, conscientious about reading the material, and asking questions. They were in their rooms studying in evenings and the afternoons and they were the ones who would sit in their rooms and do exercises. They were always asking us would the lecture be tonight or tomorrow (we have changed the time of one of them). They said, "Now are you guys going to do it for sure or not?" They seemed very anxious to have it. The other patients will go to physio because they have to, they don't seem as involved with being here. They're passing their time here hoping to get better. That's a very subjective opinion - it can't be made into a generalization for all of them but

> it's the feeling I get. I think you can tell the difference. How to measure it though? I think we should find a way. There's a woman we admitted today, for instance. She attended the old program. She came in here, felt comfortable being here, knows what to expect, and knows the sort of things she's going to go through. It's been a whole year for her. I asked her if she would be interested in going through the program again. Yes, she was interested. She didn't feel as though she knew it all. I'm sure that she could still gain something. It would be a good review for her. She must have felt as though she got some good information and wants more. The social part of it gives these patients the opportunity to talk with each other. It opens the door for them (Interview 8, Excerpt:9).

Expected learner outcomes. Beth and Ruth identified some possible expected learner outcomes as a result of the teaching program:

> Beth: I tend to think that I can expect to see some of these patients who weren't as involved, didn't try hard in the program, (I can think of one patient in particular) or didn't attend lectures, come back sooner than the others. I think the others absorbed the method of coping with their illness and ways of daily living, so that they won't run themselves down as quickly and get into such a bad state that they have to be back here for more physio or for reassessment of meds. Some of them didn't understand their medication properly before the program. They did need the information. I think they will be more conscientious or they will call their doctor and readjust as they go along, instead of waiting until it's so bad that they have to be re-admitted (Interview 8, Excerpt:10).
>
> Ruth: I'd like to see them doing their own medication. I think that would be the only way you could evaluate what they were doing. Are they taking them at the proper time? Are they taking them on an empty stomach so they get the full effect. Are they taking them lumped together? Are they taking them spaced out the way they're supposed to be? Or even are they taking enough (Interview 9, Excerpt:12)?

Staff reactions. All three nurses discussed the reactions of the staff nurses to implementation of the program. Ann had heard the staff discussing specific program patients but did not think that the staff were interested in teaching:

> Ann: I've heard the staff discussing one patient. We've had a lot of discussions about her because they're quite poor. We've been finding ways for her to get in to have her medications and to continue with her treatment. They live in a trailer park out of town. The staff think that if she's interested in looking after herself, she's going to find a way. I'm not sure that the staff nurses feel that they need to learn anymore. I think they feel pretty confident that they know a lot about [this disease]. They've picked it up, I think, on the fringes of conversation. I don't know how much some of them have read. They may have all seen the film at one time (I'm not sure about that either), but it would be interesting to test them sometime to see how much they really do know. They probably are wondering whether or not we are teaching the same thing all the time. They know that we haven't even taught the same thing two times in a row. I don't think any of them are interested. I don't think they're negative toward it. I think they're kind of proud to know it's going on, but they don't want to be involved at this point. Some of them might come around. They're certainly not coming in on their own time to attend the classes (Interview 7, Excerpt:20).

Beth thought the staff were pleased, were co-operating and were becoming more enthused about the program:

> Beth: They're pleased to see that it came off. They are very co-operative about one of us having to leave the floor, and supportive of it. I think they are starting to feel a bit more enthusiastic about it, because it's starting to come around, and they were uncertain about it before. They were leary of being totally involved. They'd never done that sort of thing before. [The acting head nurse] was saying today that she thought what had happened was that the program probably wasn't presented to the other girls in the proper way to get them motivated and to let them understand. I think they're having to see first. I have a feeling that over time, some of them will become more involved, especially once they see that it is not a scary thing. The biggest thing is the fear (Interview 8, Excerpt:11).

Ruth was getting feedback about the program, particularly about specific patients, from the staff nurses. However, she felt that the staff should be more involved, that the program needed to be reinforced on the unit and that the acting head nurse should be the one to do the motivating and reinforcing:

> Ruth: The staff nurses are starting to get feedback about the program. One of the girls said to me on Thursday night when I came in, "I got in a hassle today about not giving these pills with water. There was no water there this morning when I went it. I gave the pill at the right time, but I didn't have water there. I told her to take it when she got her breakfast." So the patients had absorbed part of it anyway, and the staff know it's going on. But we're the ones that are interested in it. They let us do it. There's no reinforcement except from the patients. I think the feeling is, "You're doing a great job and keep doing it because I don't want to." There should be more staff involvement. I don't mean in classroom teaching. There's got to be some motivation brought back to the unit. I'm probably as guilty as anyone else about it, because I'm in this blasé mood. I'm putting in time. I think there needs to be some motivation about the program, that it's an exciting thing, that it is showing some worth and that it's a valid part of nursing on the unit. The staff need to be told more often that it's going on. Some of them don't care. They could care less about the program. They're here to just file through patients. Some of them have asked our reactions and what we felt like when we were in there, and what we feel like afterwards and when we're taking care of those patients. I think the problem is that there's no motivation from the top. [The acting head nurse] could care less about the program (Interview 9, Excerpt:13).

### Tentative Conclusions and Hypotheses About Implementation of the Second Program

All three nurses who had not taught in the first program did teach in the second program. Tentative conclusions again emerged following implementation of the second program and are listed in Table 6.3. These conclusions will be discussed in the discussion section at the end of this chapter. However, one point worth noting about Table 6.3 is mentioned at this time. It is evident in the table that supporting

Table 6.3

Tentative Conclusions Which Emerged After Implementation of the Second Program
August 23-September 1, 1983

| | Conclusions | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|---|
| 2.1 | The nurses who taught the second program enjoyed the experience and felt the classes were worthwhile. | Congruent | Interview 7, Excerpt: 1<br>Interview 9, Excerpt: 1 |
| 2.2 | The nurses who taught the second program reported that the patients enjoyed the class and that the patients reported the experience to be worthwhile. | Congruent | Interview 7, Excerpt: 3<br>Interview 8, Excerpt: 2,3 |
| 2.3 | The nurses could identify observed learner outcomes. | Congruent | Interview 7, Excerpt: 3,19<br>Interview 8, Excerpt: 2,9<br>Interview 9, Excerpt: 13 |
| 2.4 | The anxiety level of the nurses decreased after teaching their first class. | Congruent | Interview 8, Excerpt: 1,3 |
| 4.a | The confidence of the nurses increased after teaching their first class. | New evidence | Interview 7, Excerpt: 17<br>Interview 8, Excerpt: 4 |
| 4.b | The enthusiasm of the nurses increased after teaching their first class. | New evidence | Interview 8, Excerpt: 4 |
| 2.5 | Two of the three nurses who taught the second program felt they had adequately prepared themselves to teach the class. | Congruent | Interview 9, Excerpt: 1 |

Table 6.3 (Continued)

| Conclusion | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|
| 2.6 Planning for implementation was not adequate. | Congruent | Interview 7, Excerpt: 17<br>Interview 8, Excerpt: 6<br>Interview 9, Excerpt: 9 |
| 2.7 Not all of the teaching nurses had developed explicit objectives and content prior to teaching the class, but rather had identified some questions, probes and exercises which they used to organize and guide the class in addition to using the material from the 'old' program. | Not as congruent | Interview 8, Excerpt: 1 |
| 7.a One of the three nurses had developed objectives and content. | | Interview 9, Excerpt: 1 |
| 2.8 The nurses who taught the program expected that the patients would lead the class and would determine the focus which the class would take. | Incongruent | |
| 8.a The teaching nurses were prepared to lead the class but were prepared to be flexible and meet patient needs in the class. | New evidence | Interview 9, Excerpt: 1 |
| 2.9 The teaching nurses were not communicating with each other. | Somewhat congruent | Interview 8, Excerpt: 7<br>Interview 9, Excerpt: 10<br>Interview 7, Excerpt: 9 |
| 9.a The teaching nurses were communicating in dyads, not as a total group. | New evidence | |

Table 6.3 (Continued)

| Conclusions | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|
| 9.b The teaching nurses were not having group meetings. | Congruent | |
| 2.10 Classes were not conducted according to the original format. | Congruent | Interview 7, Excerpt: 2,3 |
| 10.a The rotation schedule of the nurses contributed to the format change. | New evidence | Interview 7, Excerpt: 2 |
| 10.b The format change contributed to a conflict with physio. | New evidence | Interview 8, Excerpt: 3<br>Interview 7, Excerpt: 3 |
| 2.11 Seriously ill patients had admitting priority over chronically ill patients on Unit Y. | Congruent | |
| 11.a Seriously ill patients rather than the chronically ill program patients were admitted to the unit. | New evidence | Content analysis of Ruth's discussion of problems on Unit Y. |
| 2.12 The work environment was busy, interruption-laden, unpredictable and complex. | Congruent | |
| 12.a One teaching nurse is moved to a short-staffed unit for one shift. | New evidence | Interview 7, Excerpt: 9 |
| 2.13 The teaching nurses rotated at different times through different shifts so that all four nurses plus the acting head nurse never worked the same shift at the same time. | Congruent | Interview 8, Excerpt: 3 |

Table 6.3 (Continued)

| Conclusions | | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|---|
| 2.14 | The teaching nurses were not necessarily assigned to nurse their teaching patients. | Not as congruent | Interview 7, Excerpt: 19 |
| 2.15 | The teaching nurses were not soliciting feedback from each other, from the patients, from the doctors, from the staff nurses, and/or from the rehabilitation (physio and O.T.) department. | Congruent | |
| 15.a | The teaching nurses could observe and report reactions of each other, doctors and staff nurses to the program. | New evidence | Interview 7, Excerpt: 20<br>Interview 8, Excerpt: 11<br>Interview 9, Excerpt: 13 |
| 15.b | The teaching nurses had little contact with the doctors, the physiotherapy department and the out-patient clinics. | New evidence | Interview 8, Excerpt: 5 |
| 15.c | The teaching nurses needed feedback from the doctors, the physiotherapy department, the out-patients clinic, and the association. | New evidence | Interview 8, Excerpt: 3,5,6<br>Interview 7, Excerpt: 2,5 |
| 15.d | The lack of contact with physiotherapy, out-patient clinics and the association contributed to a lack of knowledge about how these departments functioned and what their role was in the program. | New evidence | Interview 8, Excerpt: 3,5 |
| 15.e | A lack of knowledge about program adoption contributed to the lack of knowledge about the departments. | New evidence | Interview 8, Excerpt: 3 |

Table 6.3 (Continued)

| | Conclusions | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|---|
| 15.f | The lack of communication between the old head nurse and the teaching nurses about program adoption contributed to the lack of knowledge of the teaching nurses about these departments and about program adoption. | New evidence | Interview 8, Excerpt: 3,6<br>Interview 7, Excerpt: 13,15 |
| 2.16 | The nurses had not identified prior to implementation what feedback to solicit and from whom. | Congruent | Interview 7, Excerpt: 20<br>Interview 8, Excerpt: 11<br>Interview 9, Excerpt: 13 |
| 2.17 | The format of the program (patients discharged after the last class) contributed to lack of patient feedback about the program. | Congruent | Interview 9, Excerpt: 4<br>Interview 8, Excerpt: 9 |
| 2.18 | Changes in program development and delivery were occurring and being suggested by the teaching nurses. | Congruent | |
| 18.a | Teaching nurses change the criteria for selection of patients for the program. | New evidence | Interview 7, Excerpt: 3<br>Interview 8, Excerpt: 3<br>Interview 9, Excerpt: 6 |
| 18.b | Teaching nurses teach the pharmacy lecture in the first week. | New evidence | Interview 7, Excerpt: 4,5,6,7 8,9,10,11,12<br>Interview 8, Excerpt: 5,6<br>Interview 9, Excerpt: 4 |
| 18.c | Patients and nurses need more knowledge about what social services are available. | New evidence | Interview 8, Excerpt:5 |

Table 6.3 (Continued)

| | Conclusions | Degree of Congruence with Findings After First Class | Evidence |
|---|---|---|---|
| 2.19 | Teaching nurses needed guidance leadership and support. | New evidence | Interview 8, Excerpt: 4<br>Interview 9, Excerpt: 13<br>Interview 7, Excerpt: 10,11, 13 |
| 2.20 | Developing and teaching the program on their own time caused problems for the teaching nurses. | New conclusion | Interview 8, Excerpt: 3,8<br>Interview 7, Excerpt: 9 |
| 2.21 | Problems with program delivery occurred when the unit leader changed. | New conclusion | Interview 9, Excerpt: 5,7 |
| 2.22 | Some teaching nurses are losing motivation. | New conclusion | Interview 9, Excerpt: 7<br>Interview 8, Excerpt: 3,6 |
| 2.23 | The teaching nurses were motivated by the ability to observe learner outcomes. | New conclusion | Interview 8, Excerpt: 8<br>Interview 9, Excerpt: 11<br>Interview 7, Excerpt: 17 |

evidence for the conclusions and new variables which appeared to influence implementation were emerging each time the program was taught. This phenomenon might be an example of what Hall and Loucks (1982) meant by "Contour Research" (1982:137):

> In a "contour research" strategy there are a series of converging thrusts rather than a single continuous narrowing in. Phenomena are studied by probing from several different angles. Heavy emphasis is placed on practitioner input for focusing the selective probes and the study design. There is interactive feedback as to the validity of the concepts and the findings. Each concept that emerges as a potential variable must "make sense" to the practitioner and must pass conventional tests of reliability and validity. Thus the ideas that emerge are contoured to fit reality as defined by practitioners and policy researchers.

It seemed as if the probes which could be used in follow-up research studies were emerging from the data.

## Implementation of the Third Program (September 6 - 23, 1983)

The third program was taught immediately following the second program from September 6 to 23, 1983. Ruth and Marg taught in this program. They, in addition to the acting head nurse, were interviewed after implementation of the third program.

Ruth did not know who else had taught in the program. She had not had any contact with the other teaching nurses. Ruth had returned early from six days off to attend a meeting of hospital nurses and to teach her class. As a result, she did not know which patients were taking part in the program. Ruth reminded the patients, whom she knew were part of the program, to attend her class. However, she neglected to inform one patient who she did not know, with the result that the patient missed the class. Ruth did not know how the other teaching nurses informed the patients about the classes. She did not know whether the other teaching nurses went around to inform all the patients or whether the patients informed each other. Ruth had taught the class Wednesday evening and worked 7 p.m. to 7 a.m. Thursday. The patients were discharged on Friday. She did not think that another program had started at the time of the interview. No family members had attended Ruth's class because most of the patients were from out of town. Ruth announced that she had now delayed resigning until the second week of January because she would receive a salary increment during the first week of January.

Marg had been off on the weekend, had worked 7 a.m. to 7 p.m. on Monday and Tuesday, and had taught the class after 7 p.m. Tuesday evening. The class was large, "10 to 12" patients. She did not know the patients and had felt "thoroughly mixed up." She was off for two days after teaching the class.

The acting head nurse was also interviewed after implementation of the third program. In early September, she had visited a large hospital in Canada in which one 40 bed unit specialized in the care of patients with this chronic disease. A full week teaching program was conducted on the unit, in that hospital, by the physiotherapists and occupational therapists. The acting head nurse reported that the doctors and nurses, in the hospital, were not involved in the program at the present time because the doctors were too busy and the budget restraints had resulted in a decrease in the number of nursing staff.

> Acting head nurse: The physiotherapist said the doctors used to be more involved but they've got so busy in their line and the nurses used to be more involved but they've got too busy and don't have the staff because of the budget (Interview 11, Excerpt:1).

The acting head nurse thought the program on unit Y was a better organized program:

> Acting head nurse: I feel ours is better organized. Actually their unit supervisor, when I explained all about mine to her said, "Well, I think it's me that should have been visiting your unit, not you visiting ours" (Interview 11, Excerpt:2).

The acting head nurse discussed the strengths of the program on unit Y. The patients had faith in the nurses because the nurses could answer questions about the disease and about the medications. In addition the nurses were with the patients every day for most of the day.

> Acting head nurse: I think a lot of it is the patients have a lot of faith in the physiotherapists, but also I think that they have a high regard for the nurses. They feel that nurses know what it's all about, probably better than a physiotherapist, from the educational point of view. There would definitely be questions they would ask a nurse that a physiotherapist wouldn't know. The physiotherapists, I find, are good from the mechanical aspect of the workings of the body parts and what they [the patients] can and can't do. But when it comes to medications and different aspects of the disease, the nurses are able to answer questions about a lot of those areas where a physiotherapist would be a bit tied down in their own area. I feel that the patients have a lot of faith in what the nurses say. They know the nurses very much on a day-to-day basis, and the nurses can pick up on things during the day (Interview 11, Excerpt:3).

Marg and Ruth discussed program development needs and program delivery problems which were emerging or continued to emerge during implementation of the third program. Ruth wanted to know if the program was making a difference to the patients. She needed a way to collect information from the patients about their behavior before and after they took part in the program. She identified the need to develop a pre- and post-program questionnaire:

> Ruth: I would like to know about the difference before they had the program and after. What had changed in their home situation. Had anything changed? Things like their household duties. Were they splitting up the repetitive activities? I'd like to know about their needs. Were they able to stick to a regimen? Did they stop something? Did they increase something? Whether they contacted the doctor when they got into problems? Did they do nothing just hoping it would go away? There's a lot of questions we could ask them. I'd like to see a post-questionnaire at the time of discharge, and then another one three months down the line. We need a pre-questionnaire. But it's hard to give a pre-questionnaire unless you catch them the day of admission, because once they've been down to physio, they've got a lot of information. Maybe it should be done before they're admitted. Maybe it should be done on admission. It is amazing, what you pick up doing your initial assessment. Someone's had it for thirteen years and knows nothing and someone else has had it for a year and has read everything that is available (Interview 10, Excerpt:1).

Ruth thought that the occupational therapist, physiotherapist and nurses should work together to identify the questions to be asked:

> Ruth: I think the input should come from O.T., physio, and nursing (Interview 10, Excerpt:2).

Marg thought that her class had an impact on the patients. She had difficulty identifying what the impact was and during the course of the interview thought that a questionnaire might be useful. It became obvious that Marg had not thought about collecting this kind of information from the patients and did not feel the need to do so at this time:

> Marg: The film gave them food for thought. They really hadn't thought about the ramifications of that film. We would have to go back to the patient and, we could if you like, ask them a few questions after. We could even set up a short questionnaire for the patients before they go home from the program. You know for me to judge what they're getting out of the program, why not ask them?
> I: Are you starting to feel a need to get some of that kind of information?
> Marg: Not yet, but if we ever get the program on the road. We've had some problems with physio. You may have heard about that (Interview 12, Excerpt:1).

Marg and Ruth had each given their lecture twice. They now wanted to give a different lecture:

> Ruth: The patients get you stereotyped. I think it's time we changed classes (Interview 10, Excerpt:3).

> Marg: I would like to do the stress one. I would like to try them all. It's a change (Interview 12, Excerpt:2).

While discussing implementation of the third program, Marg reported, as had Beth in a previous interview, that she knew little about the process of program adoption. She also revealed that the teaching program had not been considered a top priority on the unit.

> Marg: I walked into this cold. Communication was a problem for a while. I had no idea where the program came from or who developed it. There was lots of time for me to learn. Probably it was my fault that I wasn't asking more about it. Frankly, the teaching program wasn't top priority on the unit. I was invited to go on the teaching program, and I said yes (Interview 12, Excerpt:3).

Marg was having difficulty coping with what she described as a lack of continuity in delivery. Marg identified this problem when she tried to describe the reactions of the patients to the class which she had taught. She had difficulty describing the patients' reactions because she was off for two days after giving the lecture. This to Marg was a lack of continuity in delivery and could be attributed to the rotation patterns of the nurses on unit Y. In addition, the patient assignment pattern on the unit and the technology of work on the unit also contributed to the problem with continuity of delivery. Marg's solution to the problem was to appoint one teaching nurse:

> Marg: We're working a 12-hour shift. I was going off and didn't come back for a couple of days. There's not enough continuity. We should have one nurse as the teaching nurse to work in the unit and be close to the patients. It would be important that she was around either the same evening or the next day. Often the patients don't remember who taught them because it's four different nurses. That's the problem of working different shifts and having different assignments. If we're on days, I'll have between four to eight patients depending on the severity of their illness. I often won't see the rest (Interview 12, Excerpt:4).

Ruth thought that having more staff nurses involved in the program might alleviate the problem of lack of continuity in delivery:

> Ruth: If everybody gets informed and everybody wants to do it, then there won't be this hassle of "I can't do it Thursday night." That's what happened the second week. I don't know when they taught that stress lecture (Interview 10, Excerpt:4).

Marg described the "mix-up" with physiotherapy and presented this event as an example of what happened because of the lack of continuity. A related aspect of this lack of continuity was a lack of, or inability of, the nurses to communicate with each other. Ruth had taken the binder (the old program manual) home which contained the program information:

> Marg: Beth was going to do quackery or stress. Ann invited the whole unit to go in. Two ladies walked in and sat beside the physiotherapist. It was a complete foul-up because Ruth had taken the damn binder home so we didn't know what physio was doing. We were going to teach on an off night, it wasn't a Tuesday or Thursday when normally we teach. So these two ladies walked into the conference room and promptly got booted out by physio who said, "You're not in the program." They were almost in tears, "We have [the chronic illness], why aren't we in it?" We had to explain that we were sorry, this wasn't the night the nurse was going to do it. That was bad. That was poor communication and all because the binder was somewhere else. We were trying to do our thing and physio was trying to do her thing (Interview 12, Excerpt:5).

Marg reported that the nurses were not communicating with each other about the program even when they did work together. She attributed some of this behavior to the work on the unit.

> Marg: I worked several evenings with Ruth but it's never talked about. I must admit we don't talk about the teaching program in the course of conversation. I don't know why. We simply don't think about it. There's so many other things we're doing. The day-to-day jobs have to be done, there are orders for new patients, everything going on, and we just don't get time to chat (Interview 12, Excerpt:6).

This third program was the second one in which Marg had taught. She was beginning to talk about the effects on herself of the lack of continuity in delivery and of teaching the program on her own time:

> Marg: It's been a lot more hassle for me than it's been a growing process. To come back on a night off is a bind. I tried it after a 12-hour shift and that worked O.K. except that by the end of the hour I was saying a few gibberish words. I was so tired. I told the patients about a medication and mentioned the wrong dosage. The patients corrected me. It would have been a complete overdose if they'd taken what I'd told them. So it's on top of a hard day's work or a long day's work. Whether it's been hard or

> not, it's still a long shift. We talked about doing it in the afternoon. Not to have to return on our nights off or stay after a 12-hour shift. But you see we are all doing different shifts. We could probably co-ordinate it, but then, if we're assigned to a sick patient and have to leave the unit to do an hour of teaching? There are so many variables. The four of us never get a chance to talk as a group because we have such different shifts (Interview 12, Excerpt:7).

Marg stated that the problem with the physiotherapy department over criteria for selection of patients continued to exist. However, embedded in her remarks was a problem of who controlled the program:

> Marg: The nurses are in charge of the teaching program. We got a phone call from physio today to tell us who were the patients going into the next program. I guess [the physiotherapist] has been doing the selection for the patients. We will work it out hopefully, but there has been a problem between the two areas (Interview 12, Excerpt:8).

The acting head nurse was aware of some of the problems with program delivery. She was aware of the conflict with the physiotherapy department about control of the program, but thought that on the whole, implementation was proceeding quite well:

> Acting Head Nurse: I had a disagreement with the physio people as to who was running the program. The chief physiotherapist sees it in their power to control the program. I told her it isn't anymore. The nurses are running it. I explained to her how we're supposed to talk to the doctors and choose the patients. Then we sort of consult with her and see that she agrees. It's going quite well actually (Interview 11, Excerpt:4).

She was aware of the problems the nurses had coming in on their own time to teach the classes:

> Acting Head Nurse: There is only one thing I don't think is

> great. The nurses have to come back in the evening. I think that is a bit of a disadvantage, especially if they work a 12-hour shift. So we may get around to reorganizing that (Interview 11, Excerpt:5).

The acting head nurse was aware of the influence of the budget restraints on program implementation:

> Acting Head Nurse: It didn't work out as well as it could have because of the budget and what that did. Probably this program would have got going sooner if it hadn't been for all that kind of stuff (Interview 11, Excerpt:6).

However, she did not seem to be aware of the work pressure which the teaching nurses reported they were under:

> Acting Head Nurse: I think we're lucky with our staffing. This unit was set up specifically so that we would be sort of overstaffed to allow us to do things like this (Interview 11, Excerpt:7).

She was aware of the influence of the Association on adoption and implementation:

> Acting Head Nurse: We were lucky that the Association moved in and funded it. That's on a trial basis, I think until maybe the summer. If I can start getting some of those people into the teaching program in the evenings, added on to the few patients we have in there, I think they will probably continue to keep up their interest in us. You know, we obviously need them and if we can help them, all the better (Interview 11, Excerpt:8).

The acting head nurse had attended one of the Association meetings and was surprised and impressed with the knowledge of the members:

> Acting Head Nurse: They [the members] follow the research that goes on here. I was quite surprised. I went to one of the Association meetings. It's just people off the street

> with [the chronic disease] and they are the ones who are funding the program. Those women are well informed. A lot of them had their husbands or vice versa, the husband had the wife, and they seemed to be well read on what's happening. I'm so amazed at what they know about the research (Interview 11, Excerpt:9).

The acting head nurse was planning to have a meeting between the teaching nurses and herself, and among the teaching nurses, the physiotherapist and the occupational therapist in October. She described how the need for the meetings came about. The physiotherapist had suggested that a meeting be held to solve the problems about criteria for patient selection:

> Acting Head Nurse: We need a meeting with occupational therapy, physio, and all of us on the teaching program to straighten a few things out. When I was away on holidays [in early September], the physiotherapist actually got two ladies to leave the movie. When I came back I talked with her. She said, "We've never had any trouble with our opinions and the nurses before, so why is it suddenly starting now?" You know, I'm in an acting capacity, I'm new in this position. I think she felt that it would be easy for her to move back in and run the thing. I told her what the situation was. She said, "Well, we have to have a meeting". She held off having the meeting because the occupational therapist was away. This meeting is coming off within the next week or two. I want to have one first with the girls on the teaching program (Interview 11, Excerpt:10).

She identified the topics to be discussed in the meetings. In addition to discussing the problems with physio, she wanted to find out if other staff nurses were interested in teaching the program and if the problem with the nurses teaching on their own time could be solved:

> Acting Head Nurse: I want to find out if there is anyone else on the floor interested in going into the program. I

> thought there was one girl talking about it. And to see if there are any changes or if they want to try and get their teaching time during the day rather than the evening. I know two of them are having a problem with this. I can see why. I think if you're working 12-hour shifts and you end up having to come back in in the evening or hanging around here for a few hours it's pretty tiring, especially if you have to work the next day. Maybe we could organize the time a bit better. That's up to the girls. If they like this way, then there isn't a complaint. I know two of them have a problem (Interview 11, Excerpt:11).

The nurses discussed what they had observed to be the influence of the program on the activities which occurred on unit Y, on the behavior of the patients, and on the staff nurses.

The acting head nurse while identifying what she thought were the objectives of the programn, discussed the nature of nursing and what she hoped would be the influence of the teaching program on the nursing activities on unit Y. Taking part in the program would help the nurses develop a holistic approach to nursing, a sense of pride in their work, and a more humane approach to the patients:

> Acting Head Nurse: One of the main objectives in this program is to educate our patients. Instead of having a unit where they plod in, they get injections and drugs, no one tells them anything, they plod out again, and they don't really know what happens; we're trying to teach them what their disease is all about. What to expect of themselves. What not to expect of themselves. And if possible, how to educate their families. It's very hard to look at a young woman with small children, who is totally incapacitated by [the chronic disease] and whose husband doesn't understand and thinks "You lazy old thing." He doesn't know what it's all about. It makes them [the patients] so tired. It's good to see the patient and the family walking out of here with a better understanding of the illness. I think a second objective would be to have the nurses more involved in a very whole way in their jobs so it's not just coming and doing patient care and doing the paper work and leave. It becomes a continuing thing. You get marvelous feedback from the patients and you can feel quite a sense of pride in what

> you're doing. Rather than just nursing them on a bedside basis and sending them home. And nurses talking down at them [the patients]. In nursing you tend to feel that you know what you're talking about and the less they know the better. This program has been good for the nurses here because the patient is becoming more of a human being to them and this person is talking back with his or her opinions. The nurses are learning from them; things you don't know about because you don't have the disease (Interview 11, Excerpt:12).

However, when the acting head nurse described the present impact of the program on nursing on the unit, it did not seem that her second objective, as stated above, was being met:

> Acting Head Nurse: It's mentioned in report, but it's not mentioned on a day-to-day basis because the nurses know what's going on. We can see on the chart that the patient has an order for a teaching program (Interview 11, Excerpt:13).

Ruth confirmed that the program was not being discussed on the unit:

> Ruth: You don't hear much about the program on the unit (Interview 10, Excerpt:5).

Implementation of the program had an impact on the functioning of the unit, particularly in relation to the co-ordination of the unit activities with the activities of the physiotherapy department and with the activities of the residents and interns on the unit. The activities of these three, the physiotherapy department, the unit, and the residents, were interrelated. The acting head nurse explained the kinds of problems which were surfacing. The problem involved educating the residents and interns about the difference between the new teaching program conducted by the nurses and the basic physio program conducted by the physiotherapists:

> Acting Head Nurse: Our biggest problem is differentiating for the students interns or the residents, who write the orders, what type of program we mean, or the doctors mean, or the staff men mean, when they said, "This lady is for the program." We have the teaching program and then we have the basic physiotherapy. We have to be very specific. Physiotherapy and occupational therapy staff like to be very specific on their requisitions. They'll phone up if they don't understand which program is meant (Interview 11, Excerpt:14).

The acting head nurse explained the steps in the process from the time the patient was admitted to unit Y until the patient entered the teaching program one week later. Interaction occurred between and among the nurses, the interns, the residents, the chief doctors, the physiotherapists, and the occupational therapists. Insight about the decision making process also emerged. The physiotherapist should not make the decision about which patients attend the program:

> Acting Head Nurse: All this week [Week 1] we're getting patients in. Today three came in. The student interns will do the assessment. Then a resident has to go through the whole thing and check it. He will write the order for what he thinks the patient needs. In between that time and the weekend, the nurses will have been talking to the patients. They will do an assessment over a couple of days. We've usually got from Wednesday until Sunday morning to do the assessment. In that time, the requisitions would have gone down to physiotherapy for whatever the doctors wrote, either the teaching program or physiotherapy or occupational therapy or for the full teaching program. In the meantime, the nurses are getting to know the patients and finding out what does this patient want, what does he need and how far is he in the understanding of his disease? By the end of the week the nurses know their opinion of what this patient needs. On Monday morning [Week 11] we have rounds with physiotherapy and the doctors. At that meeting it's decided. Everybody throws in their opinion. I always feel the doctors give the

> nurses a lot of leeway. They know the nurses are with the patient twenty-four hours, night and day. We can see whether the patient can see, walk, sleep or whatever. Obviously, we know whether or not this patient is suitable for the program. The physiotherapist by that time has done a physical assessment of the patient. They will put in their opinion. We don't always agree 100 per cent. Actually the only disagreement the last time was about one lady. The physiotherapist said she wasn't suitable for the program because her understanding of English wasn't wonderful. I thought that was a lot of rubbish because when I spoke to the woman she knew she had [the chronic disease]. She knew she wanted to find out more about it. We let her in to our end of it, but she didn't get into theirs. She took ordinary physio but she didn't get their teaching. I felt that was very stupid. That's one area I want to clear up with them. I don't think they're in a position to tell us or the doctors what the patient needs. They can give their opinion but I don't think that in the final analysis the decision rests with them (Interview 11, Excerpt:15).

The nurses described the reaction of the staff nurses to implementation of the program. These reactions are listed in Table 6.4.

After implementing this third program, the nurses again identified, as they had after implementation of the first and second programs, the behaviors they had observed in the patients which could be attributed to the program. These observed learner outcomes are listed in Table 6.5.

The nurses identified some changes in the patients' behavior which they hoped would occur after the patients had taken part in the program. These expected learner outcomes are listed in Table 6.6.

Marg had indicated during the interview, after the implementation of the third program, that she did not know much about the history of program adoption. After the tape-recorder was turned off she began to ask questions about the present study. The investigator recognized what a poor job of communicating with Marg about the study she had

Table 6.4

Reactions of Staff Nurses to Implementation of the Program as Reported by the Teaching Nurses After Implementation of the Third Program

1. Positive Reactions
    - 1.1 the program is under discussion
    - 1.2 it gets mentioned
    - 1.3 there's a few on the brink of joining
    - 1.4 I think they like having this program being mentioned as belonging to unit Y
    - 1.5 some want to sit in on a class
    - 1.6 some say "maybe we should all do it"
2. Negative Reactions
    - 2.1 there's a few totally apathetic staff who couldn't care less if there was never a teaching program
    - 2.2 there's a few who would probably criticize it more than anything, but that's because they're a bit afraid
3. Neutral Reactions
    - 3.1 I'd have to ask them, on this floor babies are the topic of discussion
    - 3.2 there's a cross-section of opinion

Table 6.5

Observed Learner Outcomes Reported by the Teaching Nurses After Implementation of the Third Program

1. Learner behavior in class
   - 1.1 disclose own problems
   - 1.2 some patients remain quiet and withdrawn; others opened right up
   - 1.3 the patients that are accepting can talk, the patients that are newly diagnosed or non-accepting are the ones that hold back
   - 1.4 patients who are re-admitted are well informed

2. Learners want to exhibit learning
   - 2.1 identify activities they can and can't do
   - 2.2 state intention to "show" family and friends what they have learned about their disease

3. Learner relations with staff
   - 3.1 seem to feel comfortable with nurses
   - 3.2 they tell the doctors that it's a help to them and that they're learning
   - 3.3 there's not an enormous amount we can teach them because they've already read more literature on the disease than we have

4. Learners behave different than non-program patients
   - 4.1 ask more questions than non-program patients
   - 4.2 ask more knowledgable, probing questions that non-program patients

5. Learners bond with other program patients
   - 5.1 interact with other program patients
   - 5.2 form a bond with other patients
   - 5.3 talk to teach other
   - 5.4 visit each other's room
   - 5.5 remind each other of the class
   - 5.6 discover they are not the only ones with the disease
   - 5.7 state intention to "keep in touch" with program patients
   - 5.8 hold their own post-conference after each class

6. Want to learn more
   - 6.1 I've met several patients who have been in before and want to go through it again
   - 6.2 seek out teaching nurses to gain answers to questions

Table 6.6

Expected Learner Outcomes Identified by Teaching Nurses After Implementation of the Third Program

1. acceptance
2. reassurance
3. at peace with themselves
4. family acquires a better understanding of the disease
5. increased awareness of the disease
6. indication that patients understand that they can expect a remission in the disease
7. indication that patients recognize that disease is a long term one
8. gains hope
9. demonstrate compliance with exercise program
10. becomes independent
11. reports a change in home situation
    - 11.1 splits repetitious household tasks
    - 11.2 adheres to medication regimen
    - 11.3 contacts doctor when problems arise

done. The investigator answered the questions and later wrote in the field notes:

> After I finished taping the interview with Marg, she asked questions about what I was doing. I recognize the need to reinforce and communicate about the study and about my role and the nurses' role in it. Up to this point, Marg had displayed slight reluctance or irritation when I requested an interview with her. Realize now she did not understand about the study because she had not been present at the detailed explanations given the other staff. After explanation, she was very receptive and open. She said, "For a Master's type of person, you're O.K. You can interview me anytime" (Field notes: October 20, 1983).

## Implementation of the Fourth Program (October 24 to November 4, 1983)

Although the nurses indicated, after implementation of the third program, that another program would begin shortly, the fourth program was not implemented until one month later on October 24, 1983. This delay was due in part to one particular event in which two of the teaching nurses became involved. Ann and Beth did a presentation at nursing grand rounds on October 19, 1983. Marg explained that the former head nurse, before she had left, had committed the staff on unit Y to make this presentation:

> Marg: There was no program the last few weeks. We got held up because of doing grand rounds. Beth and Ann were involved in it. We will be starting next week. It's the first time we've done it. Grand Rounds are done by a unit from the hospital monthly. [The former head nurse] had suggested that we do grand rounds in October. We said we would. We were caught up in it. The acting head nurse put names in a hat and Beth and Ann and two other girls were picked. I think that's how Beth and Ann got into grand rounds. We didn't get to hear it or to see it. That was yesterday. The grand rounds went well. They did a lot of work. They did a presentation on one of the conditions that we see here. Ann is our part-time person, a B.Sc. grad, and she loves that type of research. I think she did a lot of work, probably

> most of the work, certainly the foot work. It was right up her alley. It was lucky that she got picked (Interview 12, Excerpt:9).

Ann confirmed that she had put a lot of work into preparing for Grand Rounds and had been paid to do so:

> Ann: We presented nursing grand rounds. Beth and I did all the work on that. It was a very successful presentation. I put a lot of work into it. They gave me a 12-hour day off with pay. I appreciated it. That's where a lot of my time was spent in the last month, researching and presenting. That's why this program didn't get any further along (Interview 13, Excerpt:1).

Unit Y was very busy during October. The investigator experienced difficulty conducting interviews with the nurses during this period. The teaching nurses were either not on duty or were too busy to leave the unit to be interviewed. The following field note excerpt explains why an interview scheduled for October 21 with Beth was cancelled:

> I had an interview booked for Friday, October 21, with Beth. Should have been a good day as only three patients were being discharged. Therefore, minimal possible admissions. Phoned to confirm Friday at noon. Ward clerk answered and said, "This is the worst day of our lives, is not a good day to interview" (Field notes: October 21, 1983).

The investigator phoned the unit on November 1 to arrange an interview with Ann. The interview was conducted but was almost cancelled as described in the field notes:

> I know Ann is on today.
> 11:00 a.m. I phone unit. [Acting head nurse] answers. Ann only teaching nurse on. Tells me Ann is on audit today and not available. Acting head nurse is not available either as she has a meeting in afternoon. Asks if I want to talk to Ann. I do. Ann says her audit meeting is only on over lunch

> hour. Arrange to meet her at 2 p.m. (Field notes: November 1, 1983).

During the November 1 interview, Ann reported that the teaching nurses had been involved in two meetings. The first meeting was held on October 24 and had included the teaching nurses, the acting head nurse, the area supervisor, and the director of nursing. Ann reported on what had occurred at the meeting. The nurses had outlined their needs, specifically the need for development time, the need for funding of development time and the need for more staff. According to Ann, the nurses had received no direction from the director and the area supervisor. Although Ann reported that she was enthused, it became clear that she was losing the motivation to continue working on program development. She had not been paid and wanted more recognition for what she had done:

> Ann: [The acting head nurse] had a meeting with the area supervisor to discuss where we were going with this teaching program. The area supervisor really didn't want to know much about it. She figures that it was going along fine. We got together with the area supervisor and the director to discuss the problems that we've been having. We felt that somebody had to spend more time on this program. There isn't anybody to spend any time. For example, the lectures had been given from very scant outlines. We felt the need to have the lectures written out in full. We'd like to start with pre-tests and post-tests. We want to start a system of keeping records and evaluating, and nobody has time to do that. Now, I've been writing up, in that one binder, little case studies on the patients. I've stayed over after a 12-hour shift to complete those myself. I haven't done any case studies for this group of patients that are in the program now because I've been off for about ten days and nobody else has had time to do anything. These were the questions we put before the area supervisor and the director. What's going to happen with this? We feel that somebody should be spending more time. Can the hospital afford to either hire somebody to be in charge of this

> program or pay people extra? The answer we got was, "Go to the Association" to see if they would fund us a little more. The director liked what we wanted to do in the modules. She said that maybe we could contract somebody to write those modules. At first she said, "Maybe we could pull you off your block and hire you by the hour to write modules", especially Beth and I. We seemed to be the ones who were most interested in it. We both have our degrees and I sort of think that we think alike. The director ended up saying, "Well, maybe you should go to the Association and see if they'll fund you to write it. So it ended up-- 1) They said, "Just keep a low profile on the teaching program, just carry on as it is and don't make any change", 2) "Maybe you could go to the Association and see if they'll fund you for a little more work. Sure go ahead and write your module and we give you our blessings," and 3) "Maybe we should bring in some expert on patient teaching who could help you with some of these areas." Nothing concrete really. Nothing in writing.
> I: Do you feel that you're any further ahead or that you have any more direction now than you did before?
> Ann: No, no direction from them. If I had incentive to write the modules, I could probably contract, and maybe get some money out of them. I don't know. But I don't feel the incentive to do that because as I said to the director, "I'm not interested in putting more work in this project unless I see something in it for me. I have only a part-time job here and I don't seem to be able to get a full-time job so I don't feel that I want to put in this work." She said, "That's an entirely different matter that I can't discuss here". So that's where it stood. We're carrying on with the teaching program as it was, and of course we haven't been paid at all because the computer can't digest the information, but we're working on that. The physiotherapist has been able to get money, but she went a different route. She said, "Well, I can tell you what I did down in my department but I don't know whether it will work or not" (Interview 13, Excerpt:1).

Although Ann reported that she was still enthused about the program, she wanted more support, recognition, rewards, and assurance of continuity of program implementation from the director. She was not optimistic:

> I: When I look back at the notes, I think it's been well over a month since we had a talk, at that point you were quite enthusiastic. You had lots of ideas that you were going to implement. I'm picking up quite a difference today.

> Ann: I'm still enthustiastic about the program. I think it is a good idea. I've done a lot of work on it, put in quite a few hours and I haven't been paid for it. I'm not sure how much more I want to do. If Beth and I write these modules, and we get physio and O.T. to write modules too, then I feel that I want my name on it. I didn't get from the director, that our names would be on it. We would never be given any credit for writing. The other thing, of course, is that they're waiting to hire somebody as head nurse. I don't know what their plans are, they're not telling us. I could write, I could get all these modules written before Christmas if I wanted to. I have the time. I could put all that time in and then the new head nurse would come along and change the whole thing and decide this isn't what we want. I don't know what to do. I don't think I want to put any more time in it. Then the fact that we're short on the floor and I'm only part-time and they don't even have permission to replace the people who are leaving. It leaves three of us then, Beth, Marg, and myself. So we asked them to consider hiring a person to be in charge of the teaching program, a co-ordinator or whatever you wanted to call it. They said, "No, not at this time" (Interview 13, Excerpt:3).

Ann discussed the kinds of problems that might occur when Ruth left the teaching team. The lectures were not developed in enough detail to allow someone new to the program to teach from them. The teaching nurses themselves did not feel confident enough to exchange the lectures:

> Ann: I think [one of the staff nurses] would be willing to come in and try it. We'd have to write our lectures a little better before you can expect anybody else to take over. It would be hard. We still haven't exchanged lectures which was something that we wanted to do. It takes a lot of time to prepare. It's easier to say, "Well, I'll do the pharmacy one -- I've done it already twice." I've done the stress and that's what happened for the third time now (Interview 13, Excerpt:4).

Ann reported that she needed expert help to develop and implement some of her ideas. She had discussed these needs with the director and she also asked the investigator for advice. Ann felt that she was not getting any direction from the director and felt that she could not get direction from the acting head nurse because the acting head nurse did not know the details of the program:

> Ann: I need help with the record keeping, the skills in how to do that. The director talked about a friend of hers in Ottawa. Maybe she could bring this friend here for a couple of weeks to help. Or maybe there's somebody in the in-service department who could help. Then she said maybe there's somebody in the orientation program who could come and help us for awhile. I suppose if I wrote down exactly what I wanted help with, I could probably get it. Maybe I can get some extra shifts from the Association and go ahead. I'm not getting direction from anybody. The director didn't seem to give any clear cut directions. The acting head nurse doesn't know too much about the program. She says "Just carry on and do what you can for us". I suppose if we wanted to go ahead on our own we could do it. What would you suggest?
> [Later in the interview]: I've done some writing here and I've used these resource books [points to resource books]. I don't know when I have to use references, I don't know how to document that. I've used some quotes. Should I be putting the page numbers underneath? (Interview 13, Excerpt:5).

Ann had envisioned the teaching program as being interdisciplinary. However, Ann reported that the director had made a comment during the meeting that disturbed Ann:

> Ann: The director said something a little bit disturbing. When we said we were having trouble with physio and O.T., she said, "Look, nursing can start any teaching program they want without anybody else being involved. You can teach anything you want." But I didn't think . . . that's not this teaching program, it really is an interdisciplinary program and I feel it should remain that way. I'm willing to work at keeping it that way. I don't think nursing can go off on a tangent by themselves (Interview 13, Excerpt:6).

Ann then described what had occurred during the second meeting, which was held on October 26, among the teaching nurses, the acting head nurse, the physiotherapist, and the occupational therapist. Ann reported that the meeting went well. The physiotherapist had explained the billing procedure for outpatients who were admitted to the physiotherapy portion of the program. A compromise had been reached over criteria for selection of patients. The nurses would allow some patients into the program who did not meet the criteria of the physiotherapy department and would in addition include patients from the physiotherapy portion of the program. Ann thought that the two departments, nursing and physiotherapy should and could work together on the program:

> Ann: We finally got that meeting with physio and O.T. Those two won't show up at a meeting unless both of them come. So we waited, actually we stalled for two weeks, until after we'd had our meeting with the director. It was a very good meeting. We should have had minutes and an agenda. I thought the acting head nurse was going to look after that but she didn't. The next time I think we will try to make it more formal. The director and the area supervisor didn't come to that meeting. The director was going to meet with the head of physio and the head of O.T. They told us just to iron out our problems together. So we did. I think we can work fairly well together. I don't know if physio and O.T. are interested in writing modules like this.
> I: Did you mention anything to them about the modules?
> Ann: No, not at this point, I didn't show it to them. One of the main points on the agenda was deciding when we would decide on patients for the program. Nursing will submit their list of patients to physio preferably by Thursday of week 1. Physio had a list of outpatients apparently that they call in for the program if we don't have enough on the unit. They like to call their patients in by Friday. That's why we had to set Thursday. There are two outpatients coming to this program. They go to the physio program and come up here for lectures. The program is that physio pretty well has to do that with outpatients because they need the doctor's orders and they have to do the billing for all physio and O.T. We can bring any patient into our lecture, but you can't bring them into physio and O.T. unless there's a doctor's order and it's arranged that way. We said that's fine. We are trying to co-operate with them. We bring

> patients to our lectures from the unit, and we'll continue to do that. We told them that and they said we could do whatever we wanted. Nursing tends to look at whether or not they need education. Physio still looks at the patient as being capable of learning. We have a little bit of dispute there. In spite of the dispute, I think our meeting went very well. We made them feel good. They are doing a good job and they are part of the team. We don't want to lose that team spirit (Interview 13, Excerpt:7).

Ann reported on how the fourth program was being implemented in which she was going to teach a class. She discussed the continuing problem of trying to schedule the classes around the schedules of the teaching nurses. The solution was to maintain the same teaching nights, but reorder the class:

> I: Are you still following the Tuesday, Thursday format?
> Ann: Oh, no, we have to exchange evenings because it doesn't always suit the nurse. That upsets physio because they thought that we should be able to follow the schedule to the letter. We said, "We can't follow to the letter because with a 12-hour shift somebody might be out of town on a six day trip or something." I said, "We'll use the same nights that we're scheduled for, but we'll have to switch them amongst ourselves." I have started putting up a timetable so that physio and O.T., when they come up to the unit, know exactly when we're giving what lecture. The lectures are all switched around. We have to do that because if they're working nights they don't want to take time off from the floor, or come on a day off or vice versa. I think Beth will be working nights, on Thursday night and she's going to have to come off the unit for an hour and a half and give her lecture (Interview 13, Excerpt:8).

Ann reported that leaving the unit to conduct a class caused problems:

> I: Does that cause problems on the unit?
> Ann: Yes it does.
> I: What kinds of problems does it cause?
> Ann: Well, it means Beth misses out on her coffee break. It means the other girls are short. If Beth is in charge, the

> orders are piling up on the desk until she's finished teaching, because the others probably haven't got time to do them. So it's not easy, and if it's especially busy we don't get any extra help. The nursing office is not too sympathetic towards us (Interview 13, Excerpt:9).

Ann identified learner outcomes which she had observed during the third program but reported that it was difficult to collect feedback from each patient because she was busy on the unit working with other patients. She also reported that she was just returning from days off and did not know the patients she would be teaching in this fourth program:

> Ann: One patient who went home from the last teaching session came to us and said, "You know I learned so much about [the illness]. I had no idea. All about the things I can do and can't do." She really appreciated learning about it. She said, "You provided such a nice atmosphere there on the unit. I got to know so many of the other patients who had [the illness] or had similar symptoms." She said, "This time I didn't think I'd ever enjoy my stay in a hospital, but I got to know the other ladies, I got their names and addresses and phone numbers so we could keep in touch." I thought that was nice. They really jelled as a group. I don't know these ladies as well because I've been off. I felt that that was positive feedback. But as far as individual feedback, I haven't been able to go around and ask each one. It's hard to find the time to do that. You catch comments here and there (Interview 13, Excerpt:10).

Ann discussed the reactions of the doctors to the program. According to Ann, the doctors were neutral, couldn't care less, and neither did Ann. Ann needed the doctor's order for the teaching program, but she did not need their support.

> Ann: They are very neutral on the whole matter. Physio, I think, has a bad name with the doctors. They [the doctors] don't want to talk to physio. I think it's too bad. They [doctors] really couldn't care less what we teach the

> patients. That's about how it is. Sure, they'll write the order. As far as I'm concerned, that's all we need.
> I: You're not getting any indication that the doctors are seeing that the program is useful to the patients?
> Ann: I don't think the doctors see anything. I have done some writing for the manual here [points to written material]. I have chosen a framework and developed it a bit. I have written here about support. You need legal support and you need administrative support and about the medical staff support, I've said here, "It is possible to teach effectively without the support of the physician in charge if he is neutral on the matter, but not in the face of direct opposition. Any conflict must be resolved beforehand, lest the patient be caught in the middle between medical and nursing staff." So I feel we can go ahead (Interview 13, Excerpt:11).

On October 25, the day after the meeting among the teaching nurses, the acting head nurse, the area supervisor, and the director had occurred, the investigator talked to the director. The director briefly discussed the meeting which had occurred and reported that she was going to help the unit Y staff keep their territory.

> The director said she had a meeting with unit Y staff. Physio is causing problems. The director is going to help the staff keep their territory and says, "One year ago they didn't know they had a territory." (Field notes: October 25, 1983).

The investigator felt that Ann was discouraged during the November 1, 1983 interview and wrote her impressions in the field notes after the interview with Ann:

> Ann very down, drooping shoulders, dull eyes, monotone voice. No enthusiasm or excitement today. Looks and sounds discouraged. I have the impression that this teaching group is isolated. It's not that they are being blocked in their efforts, rather that they are not being supported and guided by significant others such as the D.O.N., area supervisor, doctors, physio, other staff. Certain events are not happening. No communication with doctors, other staff. No

> liaison between out-patients clinic and the unit. Doctors aren't sending patients from out-patient clinics. Aren't spreading the word about the teaching program in the clinics. No support or encouragement from [acting head nurse]. Looks like a number of departments and people are influencing this teaching program. Looks like the layers of an onion (Figure 6.2).
> I get the impression that these patients have not received this kind of information before and some of them are long standing patients. What does the Association do? What do the doctors do?
> Ann has lost enthusiasm, is unwilling to put out extra if she's not rewarded and supported in her efforts. Teaching nurses have not been paid. Ann has not been able to obtain full-time employment. There seems to be no time for, nor does rotation permit, meetings of the teaching nurses. Ann has been the prime change agent since [the former head nurse] left. Now Ann is becoming discouraged. Is only part-time. Can't be prime change agent if not there all the time. [The former head nurse] leaving has had an impact. Commitment, support, encouragement has disappeared. [This head nurse] is only acting. Unit is in limbo.
> I wonder if the ship is sinking along with the crew and no captain is around? Ann is asking for help with module development, evaluation, and report writing. I'm in a position to help her. However, because of my role as researcher - I can't. The dilemma of the investigator! I have to go away and think about this (Field notes: November 1, 1983).

On Friday, November 4, 1983, the investigator met the director at the side door of the hospital at 4:15 p.m. The director reported that she had attended a staff meeting on unit Y on October 31, 1983. The main topic of discussion was the selection of a permanent head nurse for unit Y. The following field notes were recorded:

> Met D.O.N. walking out of the hospital at 4:15 p.m. Asked me if I'd been interviewing. Told me she'd had a meeting with the staff nurses on unit Y last Monday. She had talked with them about qualities of a leader. About whether they wanted someone with advanced preparation (a Master's). Her impression was they didn't want that because they wanted someone who would stay on unit all time. Someone who was there to "run interference" with the doctors. Director's impression was that encounters with the doctors were usually

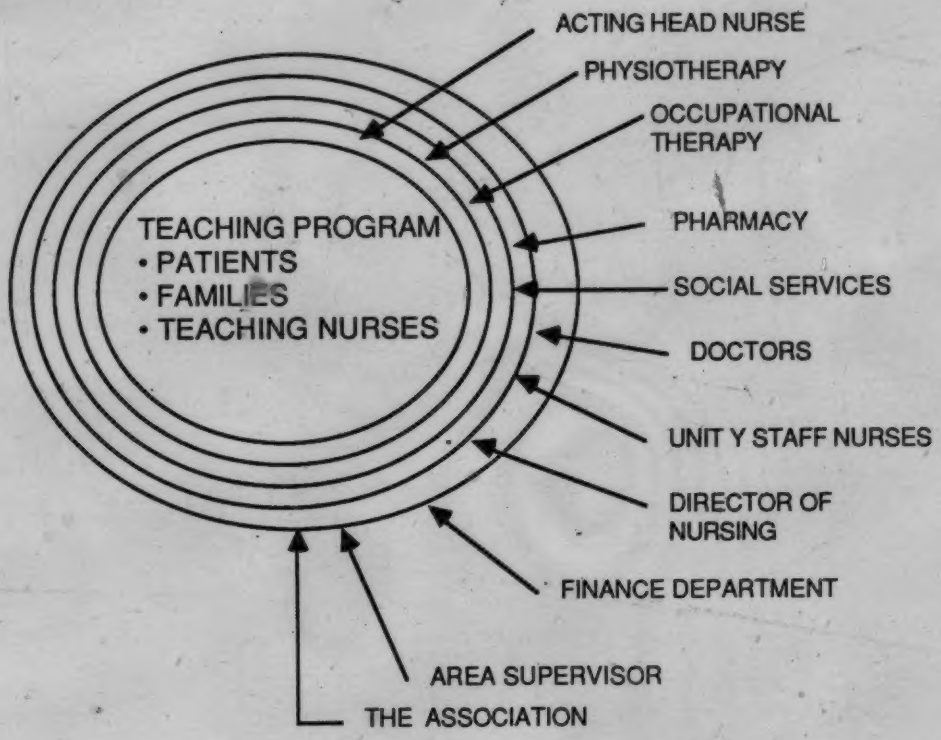
TEACHING PROGRAM
• PATIENTS
• FAMILIES
• TEACHING NURSES
ACTING HEAD NURSE
PHYSIOTHERAPY
OCCUPATIONAL THERAPY
PHARMACY
SOCIAL SERVICES
DOCTORS
UNIT Y STAFF NURSES
DIRECTOR OF NURSING
FINANCE DEPARTMENT
AREA SUPERVISOR
THE ASSOCIATION

**Figure 6.2**

Relationship Among Individuals and Groups Involved in Implementation negative experiences for the staff nurses and therefore, they wanted someone else to be there so they can get back to hands-on nursing (Field notes: November 4, 1983).

Implementation of the Fifth Program (November 14 to 25, 1983)

The investigator continued to have difficulty arranging interviews with the teaching nurses and the complexity of the work on the unit seemed to be the interfering factor. The following set of field notes illuminates the situation:

> Thursday, November 17 - Had made an appointment on Wednesday to interview the acting head nurse or Beth today at 1:30 p.m. and Friday afternoon.
> 11:15 a.m. - Phoned to confirm appointment. The ward clerk says, "It's a bad day, have been 'on take' [admitting patients other than chronically ill patients to the unit] and received a number of patients."
> 11:40 a.m. - The acting head nurse phones back, "Is too busy". She's off tomorrow. Phone her next Wednesday, November 23 at noon to arrange interview for Wednesday (November 23), Thursday (November 24) or Friday (November 25) afternoon.
> My thought: [The old head nurse] used to take Friday off as "planning day". Wonder if the acting head nurse does the same and what she does on "planning day."
> Arrange to interview Beth after 1 p.m. on Friday, November 18, 1983.
> Friday, November 18, 1983
> 11:30 a.m. - Phone unit to confirm interview with Beth. Ward clerk says Beth is off ill. No other teaching nurses on. I ask to interview one of staff nurses who is not teaching the program, who is full-time, and has been on the unit a number of months. Have to talk to someone to try to figure out what is going on. Ward clerk says there are two possibilities, [Miranda] and [Sarah]. Ask her to arrange with one of them for an interview after 1:00 p.m. She will. I go to unit at 1:00 p.m. I talked to a nurse at the desk about the interview. She doesn't know what I'm talking about. Ward clerk arrives and we meet in the hallway. Ward clerk hasn't had an opportunity to arrange interview with the nurses. [Miranda] hasn't got time, is busy and says, "Relief staff are on and we have been on take." Ward clerk goes to desk to talk to [Sarah]. I follow. [Sarah] turns out to be nurse at desk that I was talking to. [Sarah] is busy, "Got a number of admissions at noon." I leave and go to head nurse's

> office. Was a mistake to try to arrange interview on such short notice. Should always work through head nurse. See that steno pad has been set up with front part for nurses to record hours and dates worked. Shows that on November 14, Marg worked 1-1/2 hr and 1/2 hr travel and on November 17 Ruth worked 1-1/2 hr. Back section is for patients to sign an attendance record. Six patients attended class November 14 and 17. Two refused to sign names on November 17. I didn't know a class had been running this week. Questions I was going to ask staff nurses were:
>
> 1. How were nurses chosen for teaching program?
> 2. Why didn't you apply for teaching program?
> 3. What is impression of how the teaching program is going?
> 4. How does teaching program affect your work on unit?
> 5. What do you think of teaching program?
> 6. Can you differentiate between patients who have teaching program and those who don't?
> 7. What's it like on unit since change in head nurse?
>
> Thursday, November 24, 1983 - Phone acting head nurse as she has suggested. She says, "Not today, we're short of staff, our relief didn't come." She has to meet with the area supervisor. She only has two girls on tomorrow and she needs four. Informs me that Ruth leaves in February. Does acting head nurse ever fill in for the nurse I want to interview like the old head nurse used to? What has happened that these nurses can't be freed up to be interviewed? Decreased resources and staff? Decreased commitment? Is the acting head nurse committed to the teaching program? Is the hospital administration committed to this program? (Field notes: November 17 to November 24, 1983).

On December 6, 1983, the investigator received a phone call at home from Ann. Ann had been given a week of development time. The following field notes were recorded:

> Received phone call from Ann, asking me to come this week because she is on a week of development time. Will be on a different rotation in January and February. Two days off per week for development. Rest of teaching team will be off 2 days/ week for development.
> I asked how this came about?
> They had approached the director and area supervisor with problems of the program. Development time and funding was the result.
>
> My conjectures: How much effect has this present study had on the implementation of this program? Would director and

> area supervisor have responded if the program had not been scrutinized? Fullan's feedback concept is operating here. Program moved through initiation and initial implementation. They could not continue without going back to the development stage. It seems to me that a study like this has some impact on the program. Would these relations have deteriorated more if the program wasn't under study, or did physio get word of the study in progress and adjust their behavior accordingly, or did the director influence physio to become more accommodating re: the program?
> Would seem to be a good strategy to put a unit under study if wanted to ensure implementation. May not do anything for continuation, however. No institutionalization/incorporation. (Fullan, Chapter 5) (Field notes: December 6, 1983).

The investigator made an appointment to meet with Ann on Thursday, December 8, 1983. Before that meeting however, the investigator met with the director on December 7, 1983, about a matter unrelated to the study. In the course of the meeting, more information emerged about the teaching program. Excerpts from the field notes of the December 7, 1983, meeting are reported:

> The director reports that three staff on unit Y are leaving. They will be replaced. The unit is in turmoil right now. They have no leader. Unit Y has changed. It is in a transition stage. I asked the director two questions:
>
> 1. How were the staff able to be freed for development? She replied, "Surplus in summer allowed nurses to be freed up. Ann has defined the task to be done. The former head nurse had not. You can't expect a given nurse to accept an innovation that has been developed in what was perceived as a Cadillac unit and then implement it during times of restraint. We have to demonstrate ways to do things with minimum resources."
> 2. What precipitated sending Ann off for development time at this time?
>    The director replied, "The nurses on unit Y perceived problems with physio. Physio was challenged by the nurses on unit Y. The area supervisor heard of the concern. We needed to do something. I met with the teaching nurses. Told them to ignore physio and do your own thing. I sorted out money problem. They are now getting paid. I started looking at teaching

> materials with the area supervisor. [The former head nurse had reported directly to the director, bypassing the area supervisor.] I realized the program needed some development time and some reinforcement. The area supervisor showed them modules [from another program], and loaned them a development person. Physio teaching would have perceived as much better than nurses' if something not done."
>
> The director reports that the acting head nurse will be taking a L.O.A. in May. Director states she is committed to the program. My impressions:
>
> 1. The area supervisor was not involved before. Is now. The former head nurse had bypassed the area supervisor. The area supervisor had lost touch with program. Therefore, lack of knowledge, lack of commitment? (Fullan: support of central office, i.e. D.O.N., area supervisor).
> 2. There is some need to save credibility of nursing vs. another department (physio). (Fullan: competition).
> 3. They are starting to use other institutional resources: area supervisor, teaching models from other units, and other experts such as continuing education, teaching nurses, content developers. (Fullan: use of inside experts/consultants).
>
> I think I am agreeing with Guba that this is what non-participant observation is about. That is what I am doing now. (Field notes: December 7, 1983).

Ann was interviewed on December 8, 1983. At that time, she was working for one week on program development. She described the course of events which led up to the decision to give the nurses some development time. The nurses had difficulty scheduling the classes around their work rotations. They could each only teach one class because the lectures were not developed enough to allow the nurses to exchange classes. The Association wondered why the money had not been spent. The nurses had not been paid. The director and area supervisor thought the program was running smoothly until they met with the teaching nurses. After examining the teaching manual, the director realized that some development time was required. Ann had prepared a sample teaching module and had presented it to the director to illustrate what development was required. In addition, Ann had said to the director that she wanted some recognition and a full-time position before she would do any further work on the program. The result was that the nurses were paid, Ann was given a full-time position on unit Y, Ann was released from the rotation to develop the program during one week in December and three weeks in January, and the three other teaching nurses were to be released from the Unit for two days per week for three weeks in January. The release time was somewhat dependent on the staffing status on unit Y in January:

> Ann: I have this week off and I have three weeks off in January, starting January 9. After that we'll see how far we have got with planning and writing. They may free us for more time. The Association was wondering why nursing wasn't using more of the money. We were using the money they had given us for one and a half hours allotted to the teaching programs. You know nurses are always watching the pennies and we don't seem to know how to spend money. We really need to write our lectures so that we can teach each others'. Otherwise we are teaching one and not feeling comfortable with the other lectures. It was hard to schedule because if one nurse was out of town, when was she going to give her lecture? Nobody else could give it. We brought these problems to [the area supervisor] and [the director]. They were under the impression that everything was written out in the manual, that the program was running smoothly, that there was nothing more to be done but just to carry on giving the lectures. [The director] took the manual and read it. I think [the area supervisor] finally looked at it and realized that [the former head nurse] had done a lot of work but there was still a lot yet to be done. I had written out a model on my own time. I had quickly put that together and showed them what we wanted to do. That was impressive to them. They said, "Yes, that should be done and we should get a system of evaluating it and get on with it." So that's how it started. [The area supervisor] said, "We'll free you." I said, "I'm not going to put any more work on this program unless there's something in it for me. I'm only part-time on this unit and there is no future, I don't see any job for me here. I've tried to get on full-time." It wasn't long

> before there was an opening and I was given a full-time position, and I am still the co-ordinator of the teaching program.
> I: How did the Association get involved in this?
> Ann: I've been going to the meetings, and I know the president and the past-president. They were wondering why we weren't spending the money. We said, "Well, there has been a mix-up. We didn't get paid for any of our lecturing from last January until now." I think a month ago we finally got the first money because the computer just couldn't handle it and we didn't know how to bill it. We are all up-to-date now with our pay from all of the lectures.
> I: Did I hear you say, when I was talking to you on the phone, that some of the other girls were going to get release time for development in January?
> Ann: Yes, Ruth, Beth, and Marg will spend two days per week for three weeks writing the content. The area supervisor says that's tentative. She's a little bit worried about promising it definitely. She said, "You never know about the rotation, with people being sick." I said, "Well, looking at the rotation, two of them are always on their days off." Beth and Ruth are willing to work on their days off. Marg is a little bit busier. She likes her days off. Ruth and I were just talking and she says we'll write a letter if necessary to waive the contract for this time. That's what the hospital is worried about. If you work on your days off here and you work overtime you should be paid overtime. But if we're willing to work at regular time, we have to write a letter. The money is coming from the Association anyway. We're going to meet with the area supervisor tomorrow and see if we can work that out (Interview 13, Excerpt:12).

Ann explained why the problems had arisen and why the program was receiving support at this time. She felt that the hospital was committed to patient teaching, that senior nursing administration had not known about the problems before and had now reacted as soon as the problems and possible solutions were identified, and that the economic situation in the hospital had made it difficult for the department of nursing to proceed with the implementation as had been planned:

> Ann: I think that [hospital X] is committed to patient teaching. The philosophy is there. I think that when the director heard that we were floundering and discouraged and

> ready to give it up, she said, "Hey, now I think we'd better save a good thing." I don't think the area supervisor realized that there was a lot of work yet to be done. I think she thought it was running smoothly. I think that if I were to do it again, I would probably put a little more time in on my own sooner and show on paper what has to be done. You can talk about these things. I don't think talking about them is enough. I would say to anybody starting out to get it all down on paper even if it's going to cost you hours of labor on your own. It will pay off. Your proposals have to be done in black and white just like your proposals for research, otherwise the money doesn't come through. I guess in times of prosperity when there's lots of money in the budget, nursing can say, "Well we're going to start a program here this year and another one over here next year." They can do it that way and ask for volunteers who are interested in working in the program. But I guess we got caught in the middle of a recession. I think nursing management was hanging on for dear life just to keep nursing personnel and they weren't able to start any new programs (Interview 13, Excerpt:13).

Ann felt that perhaps there had been some benefits of going through this difficult period. She thought that the program now had more support; that the nurses, not administration, had developed the program; and that the nurses had kept ownership and control of the program:

> Ann: I guess it was all right to go through that period because we've got more support than we ever had. I think by going through that time, we've held onto the program ourselves. It's one thing to be told by your higher-ups or by nursing management, "You and you and you start a program or else." The other way is if a few of you believe in something and you start working on it and it's all your ideas. I suppose there's more enthusiasm when it comes from the group and we all believe in it. So we haven't received a memo from the director or someone to start a program (Interview 13, Excerpt:14).

Implementation of the Trial Run was completed. Five programs had been taught between June 14 and November 15, 1983.

## Discussion of the Trial Run

As previously mentioned in the overview section of this chapter, tentative conclusions and hypotheses about implementation began to emerge as the nurses conducted the first five programs. With the delivery of each program, the conclusions and hypotheses became more refined. By the time that five programs had been delivered, two sets of factors had emerged from the data which appeared to have influenced implementation of the Trial Run.

Factors which appeared to facilitate implementation of the first five programs and factors which inhibited further implementation and led to the need to stop and do some planning and development are identified in Table 6.7. The factors are now discussed.

### Factors Which Facilitated Implementation

Two factors emerged from the data and appeared to directly facilitate implementation. The first was that the nurses were aware of the need for the change. The second was that the nurses were motivated to implement the change. The two factors were influenced by a third factor that being the ability of the teaching nurses to observe learner outcomes. As discussed in Chapters 4 and 5, the teaching nurses recognized prior to implementation that a need for the program existed. As evidenced in the preceding overview section, all of the teaching nurses, after having taught their first class, reported that the program was worthwhile (Table 6.2 #1.1 and Table 6.3 #2.1). Throughout implementation of the five programs, they continued to report that the program was worthwhile and that the patients needed

Table 6.7

Factors Which Influenced Implementation of the Trial Run

1. Factors Which Facilitated Implementation
    - 1.1 Need for the change
    - 1.2 Ability to observe learner outcomes
    - 1.3 Motivation/commitment of teaching nurses
2. Factors Which Inhibited Implementation
    - 2.1 Clarity
    - 2.2 Complexity
    - 2.3 The adoption process
    - 2.4 Planning for implementation
    - 2.5 Leadership, support, and guidance
    - 2.6 Staff development
    - 2.7 Multiple realities

the program (Interview 13, Excerpt:10). In addition, according to the nurses, the patients also reported that the program had been an enjoyable and worthwhile experience (Table 6.2 #1.2 and Table 6.3 #2.2).

During implementation of all five programs, the need for the program was confirmed as the nurses identified learner behaviors or outcomes which they had observed and thought they could attribute to the program (Interview 5, Excerpt:1; Interview 6, Excerpt:1; Interview 4, Excerpt:1; Interview 7, Excerpt:3, 19; Interview 8, Excerpt:2, 9). The nurses frequently recounted specific instances when a patient had stated that the program had been of help (Interview 7, Excerpt:19; Interview 8, Excerpt:9; Interview 13, Excerpt:10), when they as nurses felt the program was desperately needed by a particular patient or family member (Interview 5, Excerpt:1; Interview 4, Excerpt:1), and when they thought that a particular patient who had functioned with the disease for a long period of time could have improved their quality of life had they been exposed to the program many years earlier (Interview 2, Excerpt:11).

At no time during implementation of the five programs did the teaching nurses ever express any doubts about the need for or the worth of the program. This recognition by the nurses that a need for the program existed was a primary factor which facilitated implementation of the first five programs.

The commitment and motivation of the nurses was the second primary factor which facilitated program implementation. This was related to both the need for the program and the ability of the nurses to observe learner outcomes. The teaching nurses reported that they had enjoyed teaching their first class and that it had been a worthwhile experience (Interview 4, Excerpt:1; Interview 6, Excerpt:1, 3; Interview 7, Excerpt:1; Interview 9, Excerpt:1). The nurses were motivated by the feedback which they received from the patients (Interview 8, Excerpt:8; Interview 7, Excerpt:19; Interview 9, Excerpt:11). The feedback from the patients was both verbal and in the form of observed learner outcomes (Interview 4, Excerpt:1; Interview 6, Excerpt:1, 3, 4; Interview 9, Excerpt:1; Interview 9, Excerpt:9). The nurses stated that they were teaching the program because the patients needed the information (Interview 8, Excerpt:10). Recognizing this need and observing the outcomes made them as nurses feel good about themselves and also that the experience was worthwhile (Interview 7, Excerpt:19). Although all of the nurses at various times expressed feelings of frustration and discouragement over events which occurred during implementation, they also reported that they were committed to the program because of the benefits gained by the patients (Interview 8, Excerpt:8; Interview 9, Excerpt:11). Ruth, in particular, mentioned that if it were not for the patients she would have quit after the second program had been implemented (Interview 9, Excerpt:11). The motivation and commitment of the teaching nurses facilitated implementation, and one can speculate that had the nurses not been so concerned about the patients, implementation would have ceased after the second program rather than after the fifth one.

Factors Which Inhibited Implementation

Seven factors are listed in Table 6.7 which emerged from the data and appeared to inhibit implementation of the first five programs. These factors did not appear to be discreet nor mutually exclusive, but rather were interrelated. All seven factors contributed to the recognition of a need to cease implementation in order to allow the nurses to plan and develop specific components of the program.

Clarity. A lack of clarity about the essential features of the change and about the means of implementation inhibited implementation of the first five programs. The lack of clarity about the essential features of the change became manifest on several fronts. First, while the nurses stated that the general goal of the change was to educate the patients (Interview 11, Excerpt:12) at no time did they give any indication that they had discussed, had identified, and/or had written down, what the specific goals of the program were.

Second, while the nurses were able to report on instances where they thought they could attribute observed learner behavior to the program, they had not identified, prior to implementation, the objectives or expected learner outcomes of the program or of a given class. While the nurses had indicated that the objectives for each class should be developed (Pilot Interview 2, Excerpt:4, 5, 6, 7 in Chapter 5) this was not done. Most of the teaching nurses went in to teach their first class with some questions and probes and a general idea of what they wanted the patient to learn (Interview 2, Excerpt:2, 7; Interview 6, Excerpt:2; Interview 4, Excerpt:8; Interview 8, Excerpt:1) but, in general, they expected the patients to lead the class (Interview 4, Excerpt:2; Interview 6, Excerpt:2).

The nurses were able to speculate during the interview about what some expected learner outcomes might or should be. They thought that the patients should be asked what their needs were (Interview 12, Excerpt:1). At no time during the implementation of the five programs did an individual nurse or the nurses as a group ask an individual patient or a group of patients what they expected to learn from the program. The nurses were, in fact, somewhat reluctant to speculate, and felt uncomfortable when speculating, about expected learner outcomes. They did not know how they would recognize if a need had been met or if they could attribute patient behavior with definite certainty to the program. They had no way of collecting information about patient pre-program and post-program behaviors. They did not know how to measure or interpret a difference if they found one (Interview 7, Excerpt:10, 11; Interview 8, Excerpt:9). They stated a need to develop a pre-program and post-program questionnaire (Interview 7, Excerpt:10, 11; Interview 4, Excerpt:6; Interview 10, Excerpt:1). This was not done.

Third, while the nurses had indicated in the first pilot interview that they were concerned about the lack of developed course content, they implemented five programs without developing any content. According to the first head nurse, this was to be a trial run, the nurses knew more than they thought they did, they had the content from the old program to fall back on, and they would make changes as they went along (Interview 4, Excerpt:8).

The lack of clarity about the means of implementation also became manifest on several fronts. First, the nurses had difficulty teaching the classes as scheduled (Figures 4.1 and 6.1). They had initially expressed concerns about how to schedule a lecture for a given night when the nurse giving the lecture might be on days off or working on the floor (Pilot Interview 1, Excerpt:3 in Chapter 5). The head nurse suggested that perhaps the teaching nurses would have to be prepared to give each of the three lectures rather than only one, and that the teaching nurses might have to occasionally come back from days off or after a shift to teach the class (Pilot Interview 2, Excerpt:9, 14).

During implementation of the five programs it became clear that the nurses could not teach the classes as planned (Figure 6.1). Unit Y was often busy, making it difficult for a nurse to leave the floor to teach a class (Interview 2, Excerpt:10). Ann had been sent to "relieve" on another unit on the evening she was scheduled to give a lecture (Interview 7, Excerpt:9). The patients were discharged before Beth could teach her class. It also became clear that the nurses sometimes had difficulty preparing to teach one class and although they wanted to change, did not feel prepared to give a different lecture. The teaching nurses, on the whole, gave the same lecture during all five programs (Interview 13, Excerpt:4). Attempting to co-ordinate a given class with the schedules of the nurses did create problems and what Marg and Beth described as a lack of continuity during delivery of the first five programs.

Second, the nurses had to plan and teach the classes on their own time. The nurses had initially expressed concern about the amount of preparation and teaching that would be required on their own time and about the kinds of compensation and recognition that they would receive for the extra effort (Pilot Interview 2, Excerpt:22 in Chapter 5; Interview 2, Excerpt:10). The head nurse had indicated that it would probably be necessary for the nurses to do some preparation on their own time, that a meeting should be held to develop objectives for each class, and that the nurses would be paid for their time (planning time vs. teaching time was not specified).

During implementation of the program, the nurses did prepare and teach on their own time (Interview 2, Excerpt:10; Interview 7, Excerpt:9). Ruth in particular crammed at home and while working on the unit to prepare to teach an unplanned pharmacy class (Interview 9, Excerpt:1). The nurses had attended what Ruth described as two "mini-meetings", where in her opinion nothing was accomplished (Interview 9, Excerpt:9). The objectives for only one class rather than for three classes were prepared prior to teaching any of the five programs (Interview 2, Excerpt:7). The nurses had not been paid by the end of implementation of the fourth program (Interview 13, Excerpt:1). Finally, a decision was not reached about ownership of or the form of recognition to be given the nurses for program materials produced (Interview 13, Excerpt:3). The nurses, particularly Ruth and Ann, expended extensive energies and effort on their own time to implement the first five programs. Ruth was threatening to resign and Ann said she would not continue until some of the issues were clarified (Interview 9, Excerpt:7; Interview 13, Excerpt:12).

Third, the nurses did not practice group teaching prior to implementation. The nurses were initially concerned about group teaching. They requested time to do some practice teaching to a group of staff nurses. This was not done. However, they and the head nurse predicted that they would all feel better after they taught the first class. For three of the four teaching nurses, this prediction proved to be correct. Only Beth felt that she needed more knowledge about and experience with using group teaching methods.

Fourth, the nurses did not estimate accurately how much planning time or what kind of planning would be required to implement the program. The nurses and the head nurse tried to figure out how to prepare for a given class and to identify how much lead time they would need, or have, to implement the first class. The head nurse thought that when an appropriate group of patients were on the floor the nurses could get together for fifteen minutes or a couple of hours to plan the class (Pilot Interview 2, Excerpt:14, 15 in Chapter 5). Beth thought they could meet with the patients, during the week before the program began, to decide on some kind of a class schedule (Pilot Interview 2, Excerpt:9 in Chapter 5).

During implementation it became clear that more preparation was required. Marg thought that they could have used more time, but it was impossible and unrealistic in a hospital situation (Interview 6, Excerpt:8). Ruth had prepared on the spur of the moment because she taught an unplanned class. However, she thought that the nurses had enough time, they just had not utilized it properly (Interview 9, Excerpt:9). Beth could have used one week of structured planning and development time (Interview 2, Excerpt:8). Ann thought that more time was required but that change occurred slowly and that one could not move the bureaucracy quickly (Interview 7, Excerpt:17). Finally, Ann, who had been appointed program co-ordinator, refused to continue working on the program until some issues, related to the need to release the nurses to plan and develop the program, were clarified.

The evidence indicates very strongly that it was a lack of clarity about the goals and means of implementation which literally brought implementation of the program to its knees in November of 1983. The teaching nurses had identified every one of the foregoing problem areas during the initial meetings (Table 5.6). However, there was no indication in the data that any detailed planning or attempts to resolve some of the identified issues had been undertaken prior to or during implementation. The result was ambiguity and lack of clarity about the goals and means of implementation. While the precise reasons for this are unknown, one can speculate that the nurses had very little knowledge about the components of a teaching program or about the process of implementing a teaching program. The nurses received no expert help during implementation of the five programs that constituted the Trial Run. One can speculate that although the nurses were primarily motivated to be involved in the program because of the need for the program, they were also motivated by other needs. The need for job security, the need for career advancement, the need for recognition and the need for rewards, in total could have had an overriding detrimental effect on commitment to the program. It seemed that the motivation and commitment of the nurses could not withstand the ambiguity and lack of clarity about goals and means which occurred during implementation.

One can speculate further that the head nurse did not live up to the expectations of others during implementation of the Trial Run. She had been hired because of her expertise in administration and educational matters. She had seriously considered her mandate to be that of a change agent. Among other activities, she had designed and implemented a commmittee structure on the unit, had stimulated the nurses to become involved in the nursing grand rounds and had initiated the teaching program on unit Y. However, she was busy and involved in numerous other administration activities.

There was no evidence in the data to indicate that the head nurse communicated her expertise about curriculum and program development components and processes to the teaching nurses. The teaching nurses applauded the head nurse for raising the status of nursing on unit Y. However, they did not feel that the head nurse had offered much specific, detailed, on-going support, guidance or expertise to them prior to or during implementation of the first two programs. They wondered if perhaps they should have done more of this on their own.

The current literature on change suggests that the nurses would have benefitted from more direct involvement of the head nurse. Bennis, Benne and Chin, 1985; Berman and McLaughlin, 1977; and Fullan, 1982 all indicate that change has a better probability of success when the leader (the principal, and in this study, the head nurse) takes at the least a facilitative role and at the most becomes actively involved in the change. According to Fullan (1982:135), direct or active involvement would include behaviors like meeting with the nurses, attending training sessions with the nurses, helping the nurses plan, and exhibiting expertise in curriculum planning.

The head nurse and the teaching nurses may have been suffering, prior to implementation, from what Fullan (1982:58) describes as false clarity: "False clarity, . . . occurs when change is interpreted in an oversimplified way; that is, the proposed change has more to it than people perceive or realize."

The head nurse left the unit during the second program, and a staff nurse was appointed to assume the position of acting head nurse. The lack of clarity and lack of leadership continued throughout implementation of the five programs until the teaching nurses met with senior nursing administration to present their concerns and present some possible alternatives or solutions.

It is not surprising, given the evidence in the "planning for implementation" stage about the complete absence of actual planning, that the nurses had difficulty implementing the Trial Run. However, one should not despair during this early stage of implementation, for Fullan (1982:57) reminds us that clarity is always a problem when implementing a change:

> Problems related to clarity have been found in virtually every study of significant change. In short, lack of clarity - diffuse goals and unspecified means of implementation - represents a major problem at the implementation stage; teachers and others find that the change is simply not very clear as to what it means in practice.

Complexity. Implementation of the program according to one of the teaching nurses should have been easy (Interview 2, Excerpt:8). The nurses were only teaching three classes over a period of two weeks. They had the notes from the old program to fall back on (Pilot Interview 2, Excerpt:4, 7 in Chapter 5). They all had attended school and had observed how teaching was done and two of them had attended university and been involved in some teaching (Pilot Interview 2, Excerpt:4 in Chapter 5). They had all previously taught patients on a one-to-one basis (Pilot Interview 2, Excerpt:18 in Chapter 5). According to the acting head nurse, it was her understanding that unit Y had been purposefully overstaffed so that these kinds of projects could be undertaken (Interview 11, Excerpt:7). According to the area supervisor, unit Y was "less variable" than other units and should be able to accommodate implementation of the teaching program with no problems (Interview 39, Excerpt:1). The need for the program had been confirmed (Interview 5, Excerpt:1). The teaching nurses were motivated. The head nurse had been hired because of her specific expertise in administrative and educational matters (Chapter 4).

However, implementation turned out to be a complex endeavor. It soon became evident to Beth that "things are not always what they seem", that "things do not always turn out as they are supposed to" (Interview 2, Excerpt:10, 13), and that perhaps the thoughts of the head nurse and the teaching nurses prior to implementation had been somewhat idealistic and not sufficiently clarified (Interview 2, Excerpt:13).

Seriously ill patients were admitted to the unit and the chronically ill patients were discharged early during the first program. Unit Y was regularly "on take" meaning that seriously ill patients were admitted to the unit until they could be transferred to a more appropriate unit. The unit was occasionally short-staffed and had to rely on "relief nurses" who required orientation to the unit by the experienced staff nurses, some of whom were the teaching nurses. Ann was sent "to relieve" on another unit which was short staffed the night that she was to teach a class.

The nurses were not necessarily assigned to care for their teaching patients. The nurses who were to teach a class were often not scheduled to work that evening, or were on days off, or worked the day schedule. The nurses were often not "on duty" before teaching a class and often "off duty" the day after having taught their class, making it difficult to get to know the teaching patients beforehand and to collect feedback from patients after the class.

The teaching nurses rarely worked the same shift or were very busy when they were on duty making it difficult for the nurses to communicate with each other or to conduct a group meeting other than on their own time. The nurses were busy when they were on duty which made it difficult for them to leave the floor to teach a class. If they did teach the class while on duty, they missed coffee break, orders piled up at the desk, their patients waited until the class was over to receive care, and/or another staff nurse on the unit was required to assume the duties of the teaching nurse in addition to her own patient load until the teaching nurse returned to the unit.

The nurses decided to try to teach the class on their time off.

The result was that the nurses taught after a 12-hour shift, came back to the unit on time off, and/or exchanged topics for a given class night. This resulted in the nurses becoming frustrated and the patients and personnel in other departments sometimes becoming confused. The nurses and others involved in the classes phoned in sick or were on holidays or did not show up to teach the class with the result that classes were cancelled, class nights were changed and/or the teaching nurses would attempt to prepare and present a class at the last minute. The nurses expected to be paid for teaching the class. As of October 24, 1983, the nurses still had not been paid. According to Ann, the nurses did not know how to obtain payment and were never told. The physiotherapy department had to admit patients according to specified procedures because of billing policies, whereas nursing wanted to admit patients according to educational need. Implementation, according to Marg, involved many factors and the findings which emerged from the data proved her to be right.

The unanticipated complex nature of implementation contributed to the need to stop conducting the programs and to undertake some planning and development activities before implementation could continue. These findings should not have been surprising when one remembers that the former head nurse had said that implementation of the first programs would be a trial run, that changes would probably occur and that it would all work out in the long run. However, the head nurse resigned. At no time during implementation of the first five programs did the teaching nurses remember nor were they reminded that this was a trial run. They therefore considered implementation of the first five programs to be the real thing. This situation was similar to what Smith and Keith (1971) found in the Kensington School when the primary change agent left to take another job. Smith and Keith (1971:79) reported on the effects on implementation when the leaders left: "Dependency on the participants was great and when they [the leaders] left that was the moment that Kensington died."

Fullan (1982:79) confirmed that implementation is a complex undertaking:

> Even if we get the need and the idea right, the sheer complexity of the process of implementation has, as it were, a sociological mind of its own which frequently defies management even when all parties have the best of intentions.

The adoption process. The nurses indicated that a lack of knowledge about the history of the adoption process inhibited implementation of the first five programs. Beth had not been aware of the problems which had existed prior to implementation between unit Y and the department of physiotherapy (Interview 8, Excerpt:3); of how the program was set up; of who the teaching nurses were supposed to relate to; or of the needs and expectations of the Association (Interview 8, Excerpt:6). Marg reported that she had come into the program cold, that she did not know where the program came from or who developed it (Interview 12, Excerpt:3). Although the teaching nurses had expressed commitment to the program during the adoption stage (Chapter 4), there was no evidence in the data (presented in Chapter 4) to indicate that they had participated in the adoption process.

The foregoing problems, which appear in part to be related to a lack of knowledge about the adoption process, emerged during the implementation stage. However, it should not be assumed that these symptoms would not have appeared had the nurses participated in adoption, for as Fullan (1982:64) reported, "it may come as some surprise that participation in adoption decisions and/or development is not necessarily related to effective implementation." What is important to effective implementation according to Fullan (1982:64) is the quality of the planning process:

> Rather, it is the quality of the planning process which is essential: the degree to which a problem-solving approach at the adoption stage is combined with planning ahead for implementation.

The investigator is in agreement with Fullan, for in this study, it was a lack of planning prior to implementation which had a more profound effect on implementation of the first five programs than the lack of participation in the adoption process.

Planning for implementation. There is overwhelming evidence in the data to suggest that the lack of planning for implementation was a major factor which inhibited implementation of the first five programs. Some of the effects of this lack of planning have been discussed in the preceding sections on the clarity and complexity of implementation. However, a brief summary is in order.

The first effect was that the initial lack of recognition of the importance of planning, which occurred during adoption, continued to be perpetuated throughout the implementation of the first five programs. It was evident that the nurses, and in particular the two head nurses, did not think that it was necessary to set aside specific structured planning time. The proposal for the teaching program, which was submitted to the funding agency, stated that implementation could begin in January of 1983. During the adoption period the teaching nurses did not meet as a group to discuss the program. The proposal was approved in December of 1982; however, the first program was not implemented until June 14, 1983.

By April 19, 1983, when the investigator requested permission to conduct a pilot interview, the teaching nurses had still not met to discuss the program. It became apparent, rather quickly, during the three initial meetings between the investigator and the teaching nurses, that the nurses had many concerns about implementation (Table 5.6) and that these concerns were not being addressed. It also became apparent that the nurses were only meeting because the investigator had requested the meetings. The nurses confirmed that these meetings were the only times during which planning had occurred. The nurses had only one mini-meeting during the "planning for implementation" stage. In retrospect, that label was a gross misnomer. As evidenced in the data collected during the Trial Run, the nurses in fact had done no planning for implementation of the first five programs.

The second effect was that the program elements which were critical to effective implementation had never been developed. In retrospect, during implementation of the first five programs, the nurses were able to identify numerous program components which they felt should have been developed prior to implementation. These components included objectives for each class, teaching modules for each class including specific content and learner activities, pre- and post-program questionnaires, record keeping procedures, and evaluation procedures. Although all the nurses recognized that these components should have been developed prior to implementation, Ann did state that implementation had helped her to clarify what she would now write in a module and she did acknowledge that change occurred slowly.

The third effect of lack of planning for implementation was that certain issues, which the nurses had identified as concerns and other issues which the nurses knew nothing about, emerged during implementation to become problem areas. The nurses knew prior to implementation that an old program had existed, that the content had been developed by one physiotherapist, that the physiotherapist had control over the criteria for selection of patients, and that the Association had funded the program. They voiced concerns about these facts. However, they did not know, prior to implementation, about what Beth referred to as the politics of implementation. The nurses did not know that the Association had certain needs and expectations, that the former head nurse and the physiotherapist had previously had some disagreement over criteria for selection of patients and control of the teaching program, that the doctors and the physiotherapist had previously had disagreements over certain aspects of patient care, that the acting head nurse and the physiotherapist had some difficulty reaching agreement about program ownership and criteria for patient selection, and that the physiotherapy department had certain billing procedures which must be followed. The nurses did not know about the procedures and policies of the out-patients clinic or what the expectations of the doctors were regarding the program.

It seems reasonable to assume that had the nurses, along with the head nurse, taken part in some rigorous planning and development prior to implementation, the implementation of the first five programs would have proceeded more smoothly and that implementation might have proceeded differently.

Leadership, support and guidance. A lack of leadership, support and guidance inhibited implementation of the first five programs. Statements made by the teaching nurses during the pilot interviews and during implementation of the first five programs indicated that the nurses sought out and needed leadership, support and expert guidance. They knew that they needed to develop specific program components early in the change process. They received little guidance or support which would have enabled them to undertake this development. They thought they could develop these components in a couple of hours, or one day, or one week. In retrospect, this was an unreasonable expectation.

They knew that they should collect follow-up data on the patients and should do some kind of an evaluation. They also knew, however, that they did not have the expertise to do so. They knew that they needed some practice time and some expert guidance to develop group teaching skills. None was forthcoming. They knew that while the head nurse had instigated adoption of the program, she did not have a history of following through with the detailed work or completing one task before moving on to the next one.

They thought that they were on their own, that nursing administration "did not recognize" the program. They expected no support from nursing administration, especially after Ann was "pulled from the unit" to "relieve" on another unit. They recognized that the acting head nurse was interested in the program but did not know the details. At no time did they think that the area supervisor could offer them any help. The director stated in November that unit Y was leaderless and in a period of transition. Events as described above support her statement.

One can speculate on the reasons for the lack of leadership, guidance, and support which existed during implementation. First, it became apparent very early in the study that the nurses needed help. However, the data did not produce any evidence to suggest that the former head nurse recognized that need or that she had the expertise to help the nurses. Second, the leadership of unit Y changed when she resigned. The new leader was only in an acting capacity, which resulted in a situation of uncertainty and instability for herself and for the nurses. Third, the former head nurse had reported directly to the director. The area supervisor, therefore, had not been made aware of the details of the program and was in no position to recognize a need for leadership, guidance and support or to offer any of the above if she had recognized the need. Finally, the nurses admitted that they had not supported each other very much and had lost the incentive to expend the extra effort and energy required to do so.

It was only after Ann threatened to stop working on the program that leadership, support and guidance were given to the nurses. The director listened to the teaching nurses' concerns, examined Ann's plan for program development, and examined the content of the old program. She then arranged through the area supervisor to release the nurses from their unit activities to allow them time to develop the program and to provide the nurses with expert help. It was the director who after implementation of the first program recognized the need for leadership, support and guidance and who took action.

Staff development. The lack of staff development before and during implementation inhibited implementation of the first programs. While a training session was conducted for the teaching nurses, not one of the teaching nurses attended all of the sessions. While the old manual contained the content of the old program, none of the teaching nurses had a copy of the manual, nor had they read the entire manual until they were well into teaching the classes. While the nurses requested time to practice group teaching, they never did do any practice teaching. There was no evidence in the data to suggest that the nurses were encouraged to go to the library or that books or articles were identified or made available for them to read prior to teaching their first class. Ann took it upon herself to do these activities once she had been appointed in charge of the teaching program, and Ruth was forced to do "on-the-spot" development in order to teach the class about medications. Beth continued to report that she felt unprepared but she gave no indication of having done any detailed preparation prior to or during implementation of the five programs.

Staff development sessions had been arranged for the teaching nurses prior to implementation. None were offered during implementation. However, it seems clear from the evidence, that the nurses either could not attend the development sessions or did not recognize the need to attend the sessions. This is not to suggest that all of the problems which emerged during implementation would have been solved had the nurses attended the development sessions. Ann had reported that she felt it was much easier to write the modules after she had tried to teach a class. It therefore seems that while a lack of staff development inhibited implementation, it does not necessarily follow that an abundance of staff development activities would have ensured successful implementation. Fullan (1982:66) agrees with this concept stating that, "The amount of staff training is not necessarily related to the quality of implementation". He goes on to suggest that, ". . . it [staff development] can be if it combines pre-implementation training with training during implementation, and uses a variety of trainers".

The evidence, to this point, is overwhelming that a number of factors together inhibited implementation. These factors were: (1) a lack of clarity about the goals and means of implementation, (2) the unexpected complexity of implementation, (3) a lack of knowledge about the adoption process, (4) a lack of planning for implementation, (5) a lack of leadership, support and expert guidance, and (6) a lack of staff development prior to and during implementation.

The existence of these factors, however, does not answer all the questions about the problems which occurred during implementation. Why had the nurses, as Ruth said, not utilized their time between

January and June to develop objectives and begin writing modules? Why did the nurses not seek out and make copies of the old teaching manual? Why was expert help not sought? Why did the head nurse not provide leadership? Why did the area supervisor not intervene? Why did the "tiff" with the physiotherapy department have such a profound impact on implementation of the program? Why did the nurses not seek out information about the out-patients clinic? Why did the nurses not attend all the training sessions which were provided for them? Why were practice teaching sessions not arranged? Why did it seem that the program was not being integrated into the day-to-day practice of nursing on unit Y as the acting head nurse, Beth, and Ruth had suggested? Why was the program not interdisciplinary as Ann had suggested? One other factor seemed to be having an influence on implementation of the first five programs. This was a factor or phenomenon which the investigator has called "multiple realities of the participants" which seemed to be operating during implementation of the first five programs and probably had been operating from the very beginning of the change.

Multiple realities. As reported by the investigator in the field notes of November 1, 1983, it seemed that as implementation of the program progressed a number of participants were having an influence on program delivery. In addition to the four teaching nurses and the head nurse, other major actors in this change process had emerged. These included an acting head nurse, a physiotherapist, the Association, the patients, the staff nurses, the area supervisor of unit Y, and a director of nursing services of hospital X.

A case can be made to suggest that each of these participants functioned during implementation in relation to their view of reality, and that there, therefore, existed a number of realities regarding implementation of the program. It seemed that each of the participants had formed some idea of what their own roles, needs, and expectations were in relation to the program and of its importance in the overall scheme of things, and in addition, had developed a picture of these for each of the other participants in the change. Fullan (1982:130) confirms the existence of multiple realities:

> An understanding of what reality is from the point of view of the people within the role is an essential starting point for constructing a practical theory of the meaning and results of change attempts.

The head nurse functioned as a change agent during the adoption stage. She initiated the program, obtained funding, solicited teaching nurses to volunteer to teach the program and obtained the support of senior nursing administration. However, there was little evidence in the data that the head nurse believed she had a role in the planning, development, or implementation of the change. As evidenced in the document excerpts in Chapter 4, the head nurse was involved in other roles and functions. She was the chief administrator of unit Y and, in that capacity, she was the one who interacted with the doctors, the physiotherapists, and the out-patients clinic, and who was ultimately responsible for the quality of patient care which was delivered on unit Y. She was the one who oversaw the functioning of a number of unit-based committees and the implementation of other projects which were being initiated at the same time as was the teaching program. As leader of unit Y, the head nurse took part in a number of activities which required her to be physically away from unit Y for periods of time. She sat on hospital-based committees and attended meetings with senior nursing administration.

It is not totally irrational, given the evidence about the number and diversity of roles and functions which the head nurse assumed, to suggest that the head nurse thought her role in the change ended after implementation of the first program. She had hand picked the staff for unit Y and thought they possessed the necessary characteristics to implement the mandates of unit Y, one being the teaching program. Four nurses volunteered or were asked to teach in the program. Two of those nurses had a baccalaureate degree. There is no indication in the data that the head nurse ever saw herself as the expert in curriculum and program development, as the link between the nurses and the experts, or as the person who would have to actively lead, support, and guide the teaching nurses during implementation. There is little indication in the data that the head nurse had thought about how or whether the teaching program should, would, or could be integrated into the total picture of patient care on unit Y. Although the head nurse had worked with the physiotherapy department to develop the proposal for the program, there is little indication that she viewed the program as having an interdisciplinary focus or of implementation being a co-operative effort with physiotherapy, the doctors, the out-patients clinic, the pharmacy department, and the social services department.

It seems that the head nurse thought that the patients knew quite a bit about their own disease and that they would lead the class discussions and obtain the information they needed. Evidence presented by the staff nurses indicated that the head nurse continually had to try and keep the physiotherapist under control and that the head nurse had to continually educate the doctors to the fact that nurses were professionals in their own right and not maids to the doctors. According to the head nurse, changes would occur in the program and other staff nurses might become interested in teaching the classes as time went by.

Clearly, the head nurse was operating from her view of reality. And it seems reasonable to assume that in the real world of the head nurse, the program was one of the many important things that were occurring on unit Y and among which she had to divide her time, energies and expertise.

The acting head nurse functioned in relation to her view of reality. She was a staff nurse who had been asked if she would act in the capacity of head nurse until a suitable candidate, herself not excluded, was hired into the permanent position. She had worked as a staff nurse on a day-to-day basis with the staff nurses and doctors on unit Y prior to being appointed as acting head nurse. Although she had many years of nursing experience, she had only recently obtained her registration to practice nursing in the province. She had not originally volunteered to teach in the program. She did not have post-diploma education in teaching or educational program development nor experience as an administrator.

The acting head nurse was amazed at the amount of knowledge some of the patients and members of the Association had about their disease and did not think that the nurses could really teach the patients a lot about their disease, but rather could teach them how to cope with it and be available for support 24 hours a day. She thought that the nurses knew what they were doing, thought that some of the staff nurses might gradually become interested in teaching the program, and did not pretend to know the details of the program. On the whole, although the acting head nurse was aware of the problems which were occurring, she thought that implementation was proceeding quite well. She had a vision that the goals of the program would eventually become reflected in the day-to-day practice of nursing on unit Y.

The acting head nurse appeared to be a pragmatic individual. She indicated that she knew her limitations and that she also knew she was probably being tested, particularly by the physiotherapist. She was not sure how much authority she really had. However, it seemed that she recognized that someone had to do the job and that she would probably be as good as anyone. It also appeared that she was determined to maintain the quality of patient care which had existed on unit Y prior to the change, that she would support the programs and projects which had been initiated prior to the change, and that she believed that the "rubbish" and "nonsense" which occasionally occurred, in particular with the physiotherapist, was part of the job and came with the territory.

To the acting head nurse, as with the former head nurse, it appears that implementation of the program was only one among many activities and concerns with which she had to contend. The program was part of her reality, but not necessarily a priority.

The director had her view of reality and how the program fitted into that reality. Her reality, based on evidence presented in the document excerpts in Chapter 4, was concerned with the total department of nursing in hospital X. The director supported change within the nursing department of hospital X and in particular on unit Y. She had identified the resources necessary to implement change on unit Y, among which were interested, motivated, and qualified staff. A head nurse for unit Y had been carefully selected and a reporting structure had been put in place to support the implementation of change. The most committed and interested nurses were implementing the program. Funding had been guaranteed. Expert help was available within and outside the institution. The area supervisor responsible for unit Y had experience with implementing other teaching programs in hospital X.

The evidence presented in the preceding overview section indicated that until the October 24 meeting, the director assumed that implementation of the program was proceeding on unit Y without any problems. She had not received any notification of difficulties from the area supervisor or the head nurse or the subsequent acting head nurse. However, once the director became aware of the problems with implementation, she took action. The nurses were paid from hospital funds, the nurses were released from unit responsibilities to plan and develop the program, and expert resources were identified and made available to the nurses. Communication between the area supervisor and the teaching nurses was encouraged.

The director wanted the nurses to succeed with this program. The director, according to Ann, had stated that "nursing could start any teaching program they wished." It seemed that the director wanted the nurses to realize that they were important, that they could start teaching programs and make a difference. Perhaps successful implementation would elevate the status of nursing to a professional level within the hospital. This idea is similar to what the nurses reported was the goal of the former head nurse. The director also stated that she wanted this program to be as good as the one that the physiotherapy department had taught. She felt confident that the nurses could and should meet that challenge and that she was there to help them "keep their territory". It seems that in the real world of the director, the program was one of many important endeavors which were being initiated by the nursing department in hospital X and that she, as director, had put in place the necessary structures, provided the resources and done her best to assure successful implementation.

The four teaching nurses each had their own reality and as a group had a reality in relation to the implementation of the program. Ann worked part-time on unit Y. She had over twenty years of experience in the practice of nursing at a number of different institutions. She had a baccalaureate degree.

Ann had experience with teaching patients on a one-to-one basis, but not with group teaching. Although she had not been involved in the implementation of a teaching program before, she had observed teaching programs being implemented at other institutions. She knew that program and class objective should be developed, that class content should be standardized, that record keeping procedures should be developed and that patient follow-up and program evaluation should be conducted. She was not sure of the process or the time-lines required to do these kinds of activities.

She was cognizant of the fact that this change was occurring within a bureaucracy and that she must work through the hierarchy. Evidence contained in the interview excerpts indicates that Ann was cautious about over-stepping her boundaries of authority and frequently referred to "checking" before she would take action.

Ann was interested in a full-time position and some of the other teaching nurses thought that Ann might like to become the one "teaching nurse". The evidence in the data indicates that Ann was committed to the program. Ann believed that the patients needed the program and that she could see changes in patient behaviors because of the program. She was willing and had the time to work many overtime hours on developing the program if she was recognized and compensated for her efforts.

Ann thought the program should be interdisciplinary, and that the nurses should co-operate with the physiotherapy department and the out-patients clinic. Although Ann indicated that the doctors, the staff nurses, the senior nursing administration, and the head nurses on unit Y probably supported the program, she was somewhat skeptical that they would ever get involved in the details of implementing the program. Ann was appointed to be co-ordinator of the teaching program when the head nurse resigned and it was clear that the teaching program became a priority in Ann's reality.

Ruth had been associated with unit Y the longest of any of the teaching nurses. She had worked full-time on the old unit and had moved with the unit to the new location. As evidenced in the data, Ruth was enthused about the plans which the former head nurse had for unit Y. She agreed with the professional approach of the head nurse and was looking forward to being challenged and to implementing the existing mandates on unit Y. She believed in the goals of the program. She was loyal to the former head nurse and was greatly disturbed when the former head nurse resigned and the acting head nurse took over. She felt the unit had "gone to pot", that the challenge for her to continue working on unit Y no longer existed, and that she would resign.

Ruth was active on a number of nursing committees within the hospital and knew more about the history of events in the hospital and on unit Y than did any of the other teaching nurses. According to Ruth, there was not much hope for the professional status of nursing on unit Y in light of the fact that the former head nurse had resigned and the acting head nurse was "brown-nosing" the doctors. Ruth also thought that the goals of the program should be reflected in the day-to-day practice of nursing on unit Y. However, she did not hold out much hope that this would occur because the acting head nurse was not taking any leadership in this regard ("she could care less") and although the staff nurses were supportive of the program, they were not interested in becoming involved in teaching or reinforcing it on the unit. Ruth was willing to put in many extra hours working on program development. She reiterated the fact many times she had an extensive nursing library at home, that she subscribed on her own to many nursing journals, and that she read extensively. Although she did not have a baccalaureate degree, Ruth did not rule out the possibility of obtaining one at a future date and she did not think that her lack of one in any way inhibited her effective involvement in the program.

Ruth appeared to be a self-starter and to be self-directed. She seemed to have an overall career plan in mind and wanted her work to be challenging and satisfying. However, she, too, was pragmatic and recognized the importance of things like salary increments and visibility on committees. Clearly, in Ruth's reality, the program was a priority and was an integral part of the practice of nursing on unit Y. However, she would not remain involved in the program if that involvement did not meet her own personal goals and career expectations.

*Beth* had the least nursing experience of the four teaching nurses. She began to work part-time on unit Y when it was moved to the new location. She was concerned that the patients, who were mostly older and quite knowledgeable about their disease, might consider her too young to be a credible teacher. She had a baccalaureate degree and although she had been exposed to a little bit of patient teaching in her basic education, she had always had more structure to guide her and had more time to prepare for those teaching classes.

Beth believed strongly that the patients needed the program, but was concerned about the lack of continuity of delivery and how to measure effects of the program. The evidence in the interview excerpts on the whole portrays a picture of her as being a concerned nurse, striving to become a professional nurse, and interested in gaining more knowledge. However, the evidence also indicates that Beth needed structure, guidance and support; that Beth somewhat lacked confidence; and that Beth had many other personal goals and activities in her life at the moment. Beth had done little preparation prior to implementation of the program and did little during implementation. She could identify many activities which she should have undertaken but never seemed to "get around to doing them".

Beth could distinguish between the ideal and the real world of nursing on the unit and in hospital X. She thought that all of the staff nurses should be involved, that the program should be a co-ordinated effort with the physiotherapy department, and that the program should be integrated into the day to day activities on unit Y. However, she was skeptical that the resources and the support mechanisms would be provided to allow the "ideal" to occur.

In Beth's reality, the program was certainly an important aspect, but it was not a priority. Beth seemed to exhibit characteristics of Levinson's (1978) male Entering the Adult World Period. Levinson reports that this period in the male's life usually begins about age 22 and ends at 28 or 29. He reports (Levinson, 1978:78-79) that:

> it involves a number of basic processes: exploration of self and world, making and testing provisional choices

> (cautiously, or with a great enthusiasm which masks their provisional quality), searching for alternatives, increasing one's commitments and constructing a more integrated life structure.

Work, including implementing the program, was only one aspect of the many important things that were occurring in Beth's beginning adult life at the moment.

Marg had started to work full-time on unit Y when the unit was moved to the new location. She was not aware of the history of the unit or the program. Although Marg had many years of nursing experience, she had not been involved in implementing a teaching program before. The evidence in the interview data suggested that Marg was concerned about providing good nursing care to the patients and that she believed the patients needed the program. However, the evidence also indicates that Marg was more concerned with "hands on" nursing, and with coping with the day-to-day complex and unpredictable work technology on unit Y. Marg did little preparation prior to or during implementation. She did not indicate that the program should be integrated into the practice of nursing on unit Y. Although she was concerned about the lack of continuity of delivery, she did not indicate that all of the teaching nurses and/or the staff nurses had a role in improving the situation. Rather she thought that appointing one teaching nurse to be responsible for the program might solve some of the problems.

Marg had other responsibilities in addition to her work. She was the primary breadwinner for her family. The other teaching nurses frequently mentioned that Marg's busy life did not allow her to be as flexible with her time as some of them could be and that Marg needed this job. Marg frequently mentioned that it was all right to talk about the ideal but that in the practical hospital world some things just could not be accomplished. Marg's reality appeared to be compartmentalized into discreet rather than integrated components, and the teaching program was one of the discreet components. She freely admitted that the program was not a priority on unit Y.

In addition to each of the nurses having their own reality, evidence began to emerge that the nurses as a group also had a reality. The nurses began to report that "they" (meaning nursing administration) did not support the program, that "this hospital does not recognize the program", that "chronic patients are not a priority on this unit at the moment", that "they pull us off and send us to other units", that "she (meaning the acting head nurse) is supportive but doesn't know the details of the program", that "I could put a lot of work into this program and never get any recognition", that "I might get around to doing something about it". A picture began to emerge of a group of teaching nurses who collectively thought that they were alone in this endeavor, that they were not very important, that they had little authority, that they could only react rather than proact to situations, and that they had no control over the events which were occurring around them.

One began to sense during implementation of the five programs that the nurses had little knowledge of the components of a patient teaching program and little knowledge of the process involved in implementing one, and that up until October 24th, they had received little expert guidance and support. It seemed that the nurses were being asked and being expected to internalize this change, and to undergo a resocialization process. However, they had neither the knowledge nor the resources to do so. In addition, their own multiple realities as well as those of all the other participants kept getting in the way of successful implementation.

The existence of multiple realities, or the need to internalize the change, or the need to undergo resocialization has emerged as a problem area in almost every study on the implementation of change. Fullan (1982) addressed this problem in detail when he analyzed the available literature on the implementation of change. When discussing the quality and practicality of program products development during a change he reported that: "One can see in retrospect . . . that implementation is a social process, not a delivery date (Fullan 1982:60)," and that: "Implementation is a problem of individuals developing meaning in relation to specific policy or program directions (Fullan 1982:62),"and finally that:

> . . . it is what people develop in their minds and actions that counts. Change is a difficult personal and social process of unlearning old ways and learning new ones (Fullan 1982:62).

When discussing the inconsistencies and dilemmas associated with staff development activities during implementation Fullan (1982:67) again mentioned the importance of the process of resocialization: "Implementation, whether it is voluntary or imposed, is none other than a process of resocialization. The foundation of resocialization is interaction."

The nurses and the other participants both prior to and during implementation in this study, had never really interacted to find out what each other's multiple realities were. Therefore, there was no opportunity for a process of resocialization to occur. Schon (1984), in his essay on conversational planning or dialectic, reported that the same problem occurred during policy planning. He recounted a number of examples where a lack of reflective conversation between the "planners" and the "planned-for" led to disastrous or meaningless policy implementation. He reported about one particular example:

> Popko's story of the Columbian experience suggests a conversation of planners and planned-for in which both parties constructed different and incongruent meanings for one another's utterances and were unaware that they did so. Each party acted on the basis of his own understanding, to the surprise and puzzlement of the other. The planners' disappointment with the project outcomes stemmed from their misunderstandings of the project's changing environment and of the meanings the project had for its intended beneficiaries.

Although Schon's statements focus on the planners and the planned-for, it seems that his argument in favor of reflective conversation holds some merit for this study. As has been demonstrated, to this point, the existence of multiple realities, a lack of awareness of those realities by each of the participants, and a lack of interaction or of reflective conversation between and among the participants appears to have inhibited implementation of the Trial Run.

To this point, only realities of the head nurse, the acting head nurse, the director, and the four teaching nurses have been discussed. The realities of the physiotherapist, the staff nurses, the area supervisor, the patients, and the doctors are discussed in Chapters 8 and 9. It will be corroborated at that time that indeed all of the participants in this study possessed individual realities, and that the participants never did engage in reflective conversation to enhance the process of resocialization or to enable each to understand the other's meaning of the change.

## Summary of the Trial Run

In this chapter the events that happened as the nurses tried to implement the first program were presented. The program was delivered five times between June 14 and November 25, 1983. By December 5, 1983, the problems with the program had become too great to allow implementation to continue and Ann was released from her responsibilities on the unit to begin program planning and development. The remaining three teaching nurses were to be given release time in January 1984 to take part in the needed developmental activities.

There is overwhelming evidence that the nurses had initially identified the potential problem areas for the program during implementation. There is also overwhelming evidence that the nurses knew little about, had little experience with, and received little expert guidance and support during implementation of the teaching program. The nurses were committed to the teaching program, believed that the patients needed the program, and believed (although they could not be sure) that the program was making a difference. Three factors emerged from the data which seemed to have facilitated implementation during the Trial Run. First, the nurses recognized that the program was needed. Second, the nurses thought they could observe some positive learner outcomes. Finally, the nurses were committed to implementation of the program.

Seven factors emerged which inhibited implementation during the Trial Run. The goals and the means of implementation were not clarified. Implementation was unexpectedly complex. The nurses lacked knowledge about the adoption process. Implementation had not been planned. Leadership, guidance and support were minimal during implementation. The nurses took part in minimal staff development prior to and during implementation. Multiple realities existed during implementation but were not communicated between and among the participants.

The factors which emerged are similar to those identified by Fullan in his review of the change process in educational settings. Fullan (1982) identified fifteen factors which influenced the implementation stage of the change process. The factors which emerged at this stage in the present study are compared with Fullan's factors in Table 6.8. On first inspecting Table 6.8, it appears that only five of Fullan's factors emerged from the present data to influence implementation. However, more careful inspection of Table 6.8 and a recollection of the overview and discussion sections of this chapter reveal that, if the seven factors in this study and the fifteen Fullan factors are "unpacked", only factor fourteen, the role of government, did not emerge to influence the implementation stage of the present

Table 6.8

A Comparison of Factors Associated with Implementation Identified in the Present Study with Those Identified by Fullan

| Factors Generated in the Present Study | Factors Generated by Fullan: 1982 |
|---|---|
| 1. Facilitating Factors | A. Characteristics of the Change |
| *1.1 Need | 1. Need and relevance of the change |
| 1.2 Observed learner outcomes | 2. Clarity |
| 1.3 Motivation/commitment | 3. Complexity |
| | 4. Quality and practicality of program (materials, etc.) |
| 2. Inhibiting Factors | B. Characteristics at the School District Level |
| *2.1 Clarity | 5. The history of innovative attempts |
| *2.2 Complexity | 6. The adoption process |
| *2.3 Adoption process | 7. Central administrative support and involvement |
| 2.4 Planning | 8. Staff development (in-service) and participation |
| 2.5 Leadership | 9. Time-line and information system (evaluation) |
| *2.6 Staff development | 10. Board and community characteristics |
| 2.7 Multiple realities | C. Characteristics at the School Level |
| | 11. The principal |
| | 12. Teacher-teacher relations |
| | 13. Teacher characteristics and orientations |
| | D. Characteristics External to the Local System |
| | 14. Role of government |
| | 15. External assistance |

*Factors identified in present study which were also identified by Fullan to influence implementation.

change process.

In the next chapter, what happened when the nurses were released from their unit responsibilities and finally attempted to plan and develop the program will be discussed.

# CHAPTER 7

# PROGRAM PLANNING AND DEVELOPMENT

## Introduction

On December 5, 1983, Ann was taken off the unit rotation and began to plan and develop the program. During the three weeks from January 9 to January 27, 1984, the three other teaching nurses intermittently joined Ann in the development activities. In this chapter, the events that occurred during that planning and development period are described and the factors which influenced this stage of the change are identified and discussed.

## Overview of Planning and Development

The events which occurred during this stage are listed in Table 7.1. Ann and the area supervisor had met on November 29, 1983, to discuss plans for Ann's week of development beginning December 5, 1983. The plans were documented in a memo from the area supervisor to Ann on December 2, 1983:

> RE: PATIENT TEACHING PROGRAM - [UNIT Y]
>
> This letter confirms our discussions of Tuesday, Nov. 29/83 where we planned the details of time and consultative assistance for you and the other three nurses involved in the teaching program. The following outlines the specifics for the week of December 5/83.

Table 7.1

Planning and Development Events

| Time-line | Events |
|---|---|
| December 5-9, 1983 | . Ann on a week of development time<br>. Experts contacted<br>. Ann designs a record keeping system<br>. Ruth to take L.O.A. rather than resign<br>. Beth to resign in June |
| January 9-27, 1984 | . Planning and development period |
| January 10 | . Ann visits out-patient clinic |
| January 11 | . Four teaching nurses work together<br>. Nurses work with experts<br>. Nurses visit clinic |
| January 18 | . Ann and Ruth talk to doctors<br>. Acting head nurse to take L.O.A. in May<br>. Beth and Marg work at home. |
| January 27 | . Planning and development periods end. |

| PERSONNEL | TIME FRAME | TIME | CONSULTATIVE ASSISTANCE | PURPOSE |
|---|---|---|---|---|
| [Ann] (Chair- person) | Mon. Dec. 5/83<br>Tues. Dec. 6/83 | 16 hrs. | | To identify needs of teaching program.<br>To outline plan to meet need.<br>To do literature review in library and read other patient teaching programs. |
| | Wed. Dec. 7/83 | 8 hrs. | Research Department Consultant | To discuss needs with R.D.E. consultant. |
| | Thurs. Dec. 8/83 | 8 hrs. | Teaching Nurse<br>Research Consultant | To discuss and view [another] teaching program.<br>To spend time with R.D.E. consultant writing the purpose, objectives, pre and post evaluative components of the teaching program. |
| | Fri. Dec. 9/83 | 8 hrs. | | To summarize what has been accomplished this week.<br>To identify other needs and plan the time allocated in January |
| TOTAL | | 40 hrs. | | |

The tentative plan for January would be that you'd be taken out of the rotation for another three weeks (possibly Jan. 9 - Jan. 24/84) to supervise the actual writing of the content of the teaching program. Each of the three other members of the committee, [Ruth], [Beth] and [Marg], would spend 2 days per week for three weeks with you writing the content. Modification of this tentative plan could be necessary. The costing of planning and writing this program can be charged to the funds you have for the program. Replacement costs for yourself and the other three staff nurses will be paid by [hospital X]. (Document 11).

Ann did engage in planning and development activities from December 5 to 9, 1983. She described what had occurred during the week.

Ann's Week of Planning and Development from December 5 to 9, 1983

Ann reported that the acting head nurse was supportive of the program:

> Ann: [The acting head nurse] is very supportive, she's pushing right ahead. She's paving the way to the doctors (Interview 14, Excerpt:1).

Ann stated the doctors were interested in the program:

> Ann: The doctors are interested in the program and they're writing the orders on the patient's chart now and bringing patients in for the teaching program alone (Interview 14, Excerpt:2).

Ann had contacted the head nurse in the out-patient's clinic. The head nurse was supportive of the program.

> Ann: I'm going to spend a day in the clinic in January. The head nurse is very supportive in the out-patients clinic. She's very anxious that I come. She's done a survey that may be of help showing us the teaching needs she sees in patients (Interview 14, Excerpt:3).

Ann received expert help. She had been talking with three other teaching nurses in hospital X. A nurse from the research department had been assigned to consult with Ann about program development:

> Ann: I've been to talk with three other teaching nurses and looked over their programs. I have some good ideas. A nurse from the research department has been designated as our helper and consultant. She's going to spend a day each week

> in January with us. She's very excited about the program. She's just finishing her master's degree and has some ideas (Interview 14, Excerpt:4).

The area supervisor had provided the liaison between Ann and the experts:

> Ann: I asked to see some of the other programs. [The area supervisor] was good about making the contacts. I've had a good response. They're willing to help us anytime (Interview 14, Excerpt:5).

Ann began to develop a system of record keeping:

> Ann: We have a system that we're going to use to keep track of the patients. [The area supervisor's secretary] is going to do the typing for us. That's the beginning (Interview 14, Excerpt:6).

Ann planned to talk to the doctors about the program:

> Ann: I haven't talked with the doctors. I hope to do that after I sit down in the clinic. I will probably be going with one of the doctors all day (Interview 14, Excerpt:7).

Ann was talking to the staff nurses more about the program. She posted a lecture schedule on the unit for the staff nurses. The staff nurses were referring patients to her as the teaching nurse, and Ann thought the nurses would become more interested once they could read a completed teaching manual:

> Ann: We talk about it more. It's become a big thing. The staff nurses know the schedules of the teaching program. The nurses tell the patients, "Tonight there's a lecture, don't forget." We don't have to go around and remind the nurses as much. I've been putting the schedule up on the bulletin board when the lecture is running. They'll come to me and tell me that Mr. So and So has some questions for me. Then I

> go and talk to him. When we get the program written up, when we have a copy of the manual on the ward, then I think that all the nurses will be interested. Right now there isn't anything specific to read (Interview 14, Excerpt:8).

Ann began to formulate plans for development of the teaching manual. She identified the content of the manual and was gathering information to have ready for development activities in January.

> Ann: I wrote up a list of the proposed content that I want for the teaching manual. My job will be to compile and gather the information (Interview 14, Excerpt:9).

She typed a list of the proposed contents of the teaching manual. The manual would contain a philosophy statement, a statement of the purpose and goals, the criteria for selection to the program, a description of the four components of the teaching program, a patient discharge booklet, 14 teaching modules (six being modules which the rehabilitation team presently taught, three new modules which the nurses should develop and one module which the nurses would take over from the social services department), and four future modules which should be developed and were specific to related diseases:

### Proposed Content of the Teaching Manual

1. PHILOSOPHY STATEMENT - comprised of [hospital X] Nursing philosophy, [unit Y], philosophy, and patient teaching philosophies.
   a. Framework for a patient teaching program based on the nursing process and modified to suit patients [with the chronic disease].

2. PURPOSE AND GOALS - a broad statement of the objectives of nursing in the teaching program.

3. CRITERIA FOR SELECTION OF PATIENTS - at present, the patients on unit Y and, in the future, patients throughout

the hospital and out-patients from the out-patients' clinics.
- a. An admission assessment questionnaire to be used by nurses to determine the education needs of patients.
- b. A detailed list of nursing-care-plan directives for nurses caring for the patients who are enrolled in the teaching program.

4. DESCRIPTION OF THE TEACHING PROGRAM
    - a. Medical
    - b. Nursing
    - c. Physiotherapy
    - d. Occupational therapy

5. PATIENT BOOKLET - to be compiled from teaching modules and given to patients upon discharge.
    - a. Information on each topic summarizing material taught in program.
    - b. Suggested helps to use at home.
    - c. Suggested extra readings on each topic.

6. TEACHING MODULES
    - a. What is [the disease]?
    - b. Diagnostic tests [a new module]
    - c. Medications
    - d. Stress management
    - e. Quackery
    - f. Pain control [a new module]
    - g. Community resources [take over from the social services department]
    - h. Diet and nutrition [a new module]
    - i. Rest and activitiy
    - j. Isometrics and range of motion
    - k. Hand care
    - l. Foot care
    - m. Heat versus cold
    - n. Splints and aids for activities of daily living

    [Rehabilitation team presently teaching]

7. FUTURE TEACHING MODULES
    [Four modules specific to related diseases] (Document 12).

Ann identified other components of the program in addition to the contents of the teaching manual which should be developed. These components were of the evaluation/assessment nature. She wanted to develop a patient assessment sheet, guidelines for nursing care plans, a pre-test, and patient follow-up procedures.

> Ann: After the manual, we want to implement a system for evaluation of the program. We want to develop an assessment sheet for the patients who are admitted to the program to determine their educational needs. We'd like to develop guidelines for nursing care plans for the unit specific to the teaching program. We hope that through those nursing care plan guidelines all the staff nurses will encourage the patients to follow the timetable of the teaching program and that the staff nurses will encourage patients to take full advantage of rest periods outlined in the program, and will encourage patients to verbalize concerns which arise during hospitalization, then the areas of concern can be addressed in the teaching program. We have to think of some type of pre-test, perhaps in connection with the assessment sheet. Maybe the pre-test could have questions from all the teaching modules. Then the follow-up, the evaluation by phone or letter to be carried out a month after discharge of the patient. This is something we would like to recommend in January. After we've worked on the program thoroughly for three weeks, we'll have a list of recommendations (Interview 14, Excerpt:10).

Ann had benefitted from seeing information about the other patient teaching programs in hospital X:

> Ann: I've benefitted from seeing these other programs. I realize that we've got the content under control and we have a plan (Interview 14, Excerpt:11).

Ann stated that it was important to prove that the program was worthwhile. She was concerned about how to collect the data:

> Ann: But's its these reports and keeping statistics that we have to devise through our own methods? It's the statistics that are going to prove for us the importance of the program. I mean we can teach until the cows come home, but if we don't have anything to prove that it's worthwhile, pretty soon it's going to be dropped. That's very important (Interview 14, Excerpt:12).

She was feeling more confident about the program development now that she had received expert help and she thought the program was receiving support. She began to identify areas for program expansion:

> Ann: I'm feeling more confident. I know who to go to when I need help. I feel that everybody's very supportive of the program, like [the head nurse] in the out-patients' clinic. I can see ways that we can expand the program (Interview 14, Excerpt:13).

Ann discussed how she was going to plan for the three development weeks in January. She might not do much except gather materials and get the other three teaching nurses to do the same:

> Ann: I may not do much work on the program except to gather material that we can use and get the nurses who are involved to gather material for their modules. I'm on an ordinary rotation between now and January 9th (Interview 14, Excerpt:14).

Ann had been communicating with Ruth in particular about her plans for program development in January:

> Ann: They're aware of what I've been doing. Ruth has been reading my plans. She helped with some of the comments. I've tried to include the other two on an informal basis. It's hard to get together. I feel sometimes that I'm making too many decisions on my own. Yet they seem to be happy that I'm going ahead. I said, "It's not written in stone. Anything that I'm writing down is just a guideline and can change" (Interview 14, Excerpt:15).

Ann also reported that Ruth had decided not to resign but that Beth would be resigning in May or June.

> Ann: Ruth is not leaving. She is anxious to go on her holiday and come back. She's interested in the program and being part of it. Beth will be leaving in May or June. She's going to be travelling. We'll see if somebody else wants to come and take over (Interview 14, Excerpt: 16).

The unit was going to undergo one other change. The acting head nurse reported on January 6, 1984, that she would be taking a leave of absence for about six months beginning in May of 1984. Another acting head nurse would be appointed for the unit. This would be the third head nurse on unit Y in the 17 months since the program had been adopted.

## Three Weeks of Planning and Development in January 1984

The four teaching nurses worked together intermittently from January 9 to 27, 1984. Ann, as co-ordinator of the teaching program, worked on program development activities every day for the three weeks. The other three teaching nurses worked on the days listed in Table 7.2.

By December 9, Ann had typed up a list of the proposed contents of the teaching manual (Document 12) and had identified other components of the teaching program (Interview 14, Excerpt:10) which she thought the group of teaching nurses should begin to develop during the three weeks in January. Between December 9 and January 11 (the first day that all four nurses worked together), Ann collected a number of papers and articles and made photocopies for the rest of the teaching nurses in preparation for the first development week. She also began to develop the statement of philosophy and the goals and objectives of the teaching program. She hoped that all the teaching nurses could have a brainstorming session on Monday of the first week, and that by the end of the first week, numbers one to five on the content list (Document 12), which included the philosophy statement, the purpose

Table 7.2

Office Schedule of Teaching Nurses for Planning and Development Activities

| Week | Days of the Week in January 1984 | | | | |
|---|---|---|---|---|---|
| Week I | 9 | 10 | 11 | 12 | 13 |
| | Ann | Ann | Ann<br>Ruth<br>Beth<br>Marg | Ann<br>Marg | Ann |
| Week II | 16 | 17 | 18 | 19 | 10 |
| | Ann<br>Ruth | Ann<br>Ruth | Ann<br>Ruth | Ann<br>Ruth | Ann<br>Ruth |
| Week III | 23 | 24 | 25 | 26 | 27 |
| | Ann<br>Marg | Ann<br>Beth | Ann | Ann | Ann |

and goals, the criteria for selection of patients, a description of the teaching program, and the patient booklet, would be completed. However, the teaching nurses could not work together until Wednesday. Therefore, Ann worked alone on Monday and continued to develop the statement of philosophy and the purpose and goals of the teaching program. She did not think that Monday had been a productive day for her, and she was reluctant to develop materials without the other teaching nurses:

> Ann: I made copies of papers and references so that we could each be looking at them and working on them. I got nursing textbooks and teaching books from the library. I brought those to their attention. I had to arrange with the acting head nurse and the girls which day was suitable for them to be off the unit. There wasn't much choice. Wednesday was the only day. I had to go ahead on my own on Monday. I really wanted that brainstorming session on Monday. I felt as though Monday wasn't as productive as it should have been because I hesitated to go on writing without them (Interview 21, Excerpt:1).

Ann did not give a copy of the proposed contents of the teaching manual or the articles which she had photocopied to the rest of the teaching nurses until Wednesday morning. She explained that the rest of the teaching nurses had been on the unit Monday and Tuesday, that the nurses had come in and out of the office to see what she was developing, and that Ruth and Beth knew what to prepare for Wednesday morning when all the nurses would begin to work together. According to Ann, Ruth and Beth had come prepared on Wednesday:

> I: When did the rest of the team receive the material?
> Ann: They got copies on Wednesday, but they had been on the unit Monday and Tuesday. They were in and out of the office. So they had seen it before, I didn't want to go

> ahead, and say, "Well this is the way it's going to be." I tried to check with them and explain what I was doing and ask if they had any other ideas. Ruth knew that we would try to talk about her medication unit on Wednesday. She had her material with her when she came. She had picked up different books and had been talking to pharmacy. She'd done quite a bit of preliminary work. The same with Beth. She had gathered some of her information for quackery (Interview 21, Excerpt:1).

On Wednesday, the teaching nurses began to collectively develop the program. This was the first time that the four teaching nurses had worked together for a concentrated period of time since the program was adopted in December of 1982 and, as the remainder of this report will confirm, it was the only time that the nurses would work as a group during the development period or the remainder of the study period. The four teaching nurses were interviewed immediately after the Wednesday development session. The results of those interviews are reported in chronological order.

Ruth was interviewed Wednesday afternoon after having spent a morning in planning sessions with the other three nurses. Ruth had formed some expectations prior to the planning session. She knew that they would be working on the first three items on the content list:

> Ruth: I came with my ideas established as to what I expected. I had thought about it. I knew we were going to go over the three areas (Interview 18, Excerpt:1).

Ruth and Ann began working at 9 o'clock. However, no starting time had been specified and Marg and Beth arrived late:

> Ruth: We started about 9:00, but we really didn't get into it until 10:00 or after because Marg kind of staggered in. We didn't all come at a set time. Beth didn't come until

after (Interview 18, Excerpt:2).

Ruth and Ann did some writing on the philosophy, purpose, and goals and made photocopies for Beth and Marg. They arranged for a time to meet with the nurse from the research department. When Beth and Marg arrived, the nurses began to discuss the first three items on the content list.

Ruth became discouraged about some of the activities of the morning session. She wanted to do a proper job the first time but she felt that the other nurses just wanted to do the best they could at the time and make additions later. Ruth thought that the work completed was superficial:

> Ruth: I was a little bit discouraged this morning. While we've got the time, we should do a thorough job. It may take a little while longer. I'm not a person to do things half way. I got the feeling this morning that the girls were thinking "We've got to try, we'll do the best we can for the moment, and we'll add to it later." This is very superficial (Interview 18, Excerpt:23).

She felt that the nurses agreed on the statement of philosophy and the purpose and goals of the program, but that they had become bogged down in the criteria for selection of patients to the program. She thought that the other nurses were having difficulty because of pre-conceived assumptions which they made about the physiotherapy department and the doctors. She thought that the nurses should talk to the other involved departments. According to Ruth, a new social worker had been hired who was enthused about the program, but nursing was now talking about taking over that lecture also:

Ruth: We got bogged down with the criteria. That was where I was having a lot of trouble. The criteria we set up this morning is too narrow. It's only a nursing criteria with a doctor's order. I'm perceiving that the negative feelings that have been floating around in the past with physio and medicine have been passed down and we haven't addressed the people concerned. The other nurses don't feel that physio and medicine will be receptive and want to get involved and help. I disagree. You see it really affects my pharmacy lecture. I have to know what the medical people think. I want to go and talk to each one of the doctors because they all prescribe different drugs and I don't want to overstep my boundaries. I think the nurses have a pre-conceived assumption based on feelings that were brought out when we first moved to the new location. I don't think it's true feelings. I don't get that negative perception because they [the doctors] trust our judgement. The doctors said right out, they support us in anything we do. I'm sure that if they were encouraged, but they have never been encouraged before. The nurses said, "The doctors won't be receptive." I said, "I know a resident who will help us." They said, "Ah, he won't." I talked to him, he was up here this morning. He said, "Sure." He said, "You know what? I'm sure Dr. [Z] would be more than willing and would be honored if you asked him." This program was a takeover situation. It was, "We're going to do this." It's not, "Let's do it as a team." The girls are afraid to do it as a team, to have medicine, physio and O.T., nursing and social services, all sit down and do it. Now they want to take over the social services lecture. I talked to a new social worker from the unit. He's young, he's very eager, he's almost over-anxious. Before, we had to hound that area. He's up on the unit three times a week. He's more than willing to help. When I mentioned this to the rest [of the nurses] they just fell over. I think a lot of it's an approach, not demanding, but making them [the other departments] feel like they're a worthwhile part. We were talking about the criteria for in-patients and out-patients. The problem with out-patients was, would physio teach if it was an out-patient lecture and would they allow them [the patients] into their lecture? I don't think they've [physio] been approached. They [the nurses] are assuming that it won't work. Why throw up your hands in despair until you've confronted the problem? We shouldn't go down and say, "We think there should be out-patients in the program and you have to come and teach." It should be like, "This program is funded, it's for the betterment of us all, it's on your off time, but you're paid adequately for it." We should encourage and promote this program because they [physio] did the groundwork and I think they need a big pat on the back for taking over when nursing could care less. Physio and O.T. set up the program. I

> don't want to see us carry on a power struggle that was between the [former head nurse] and the physiotherapist. It was a personality conflict between the two professions and that's what we're carrying on (Interview 18, Excerpt:4).

Ruth had thought that the nurses would talk to the doctors during the morning. However, the plans had not been made and the nurses did not talk to the doctors:

> Ruth: Today is rounds. We were planning to talk to the doctors. We knew they would be available. I thought it had been set up. It wasn't. We didn't talk to them. It's planned for next Wednesday (Interview 18, Excerpt:5).

Ruth thought that Ann, the leader, was losing ground and had not been prepared:

> Ruth: The leader was losing ground. Any time I've been involved in the leadership of a group, you come prepared, you know your plan may change but you come prepared. It isn't just come and meet and all of a sudden these wonderful ideas come to mind. Maybe that's the way it's supposed to be. I don't know (Interview 18, Excerpt:6).

Ruth commented on the group dynamics of the morning. She thought each of the nurses was playing out a role and meeting her own needs:

> Ruth: The other interesting thing that came up this morning was the group dynamics. Ann's been delegated to be the spokesman. Everyone was jostling for a role. It was amazing, you should have been here. You could just see it. Due to the personalities involved, nobody is going to sit back and not be heard. I have a very strong feeling of what each role is. I don't know whether I perceive it right or wrong, I'd like to know. I see one as seeing this little program as a stepping stone to a career of the future. I see two of us having the same role, objectives, and goals. I see the other as (I don't know whether she feels it) being here because it is a good place, as though all of a sudden it has some status and is financially secure, but doesn't want to put too much of herself into it. I don't know how far off in

> left field I am, but I get that feeling (Interview 18, Excerpt:17).

Ruth would not be working on development activities again until the following Monday. She had made plans for that period:

> Ruth: I know what I plan to do and I'll inform everyone. I don't want to get bogged down on this criteria because I'm going on holidays for six weeks. I want that pharmacy lecture completed. I can give it with no problem. I want it so that with very little research, somebody else should be able to give it from what I have developed (Interview 18, Excerpt:8).

Beth arrived late for the Wednesday planning session. She didn't have the energy to come earlier. She had to come in on a day off between the three days she had just worked and the three days she would be working. She did not know what the group would be doing and she felt that the group was disorganized:

> Beth: I was only in from 12:00 to 4:00. I was supposed to come in the morning. Frankly I had a hard time getting here. I'd worked for three days and only had one off. Even though we were being paid, I didn't have the energy. I wasn't sure of what they were going to be starting on when I got here. Also, I didn't think that we'd get a heck of a lot done, so I wasn't concerned about coming. I decided to make it a half day instead of a full day (Interview 19, Excerpt:1).

When she did begin to work with the group, Beth found that the criteria had not been clarified, that it was hard to get down to brass tacks, that everyone had different ideas, that it was hard to concentrate, that it was hard to work in a group, and that some of the group (herself included) really did not know how to do development activities. She thought that the development work which was done on two of the modules had been an accomplishment, that everyone had good ideas and that she could begin to visualize a finished product. She thought that being given the development time was a form of recognition:

> Beth: They'd gone through the criteria for admissions into the program. They hadn't clarified it very well. I found it hard to get down to brass tacks. It was hard to sit down and write the final copy. We wrote the purpose and objectives for two of the modules and decided on what information we were going to add to another. That was good. We had accomplished something. Working in a group is hard. Some of us have never done it before. I didn't feel, from having talked to the girls ahead of time, that they were organized. I don't think they know how to organize themselves. It was hard to get our opinions together because everyone has an idea of what it should be like. It's good though. Everybody has good ideas. But that makes it hard to concentrate. I could only concentrate for an hour. You go at it, you stop and relax, you chat, and get your bearings together and then go back and think about it. I can see where it will be a finished product now. I don't think I could see it before. It felt good to know that they're allowing us time to come in and work (Interview 19, Excerpt:2).

Beth thought that the leader could have been more forceful during the activities on Wednesday and that the group still needed more expert help:

> Beth: Ann is enthusiastic, but she's not forceful enough. She can get us going up to a point. Some people have to be led and told. The other girls didn't realize what objectives were for and how they were to be written. You have to work with them, and explain, "This is how it should be done." They didn't realize that there is a procedure and there is a certain way of writing. It's a good experience but I think we might have benefitted if someone came and said, "This is how you do a project like this, these are the steps you take." We didn't know and we still don't know (Interview 19, Excerpt:3).

Beth thought that communication with the doctors should be improved because the nurses wanted to allow out-patients into the program. The doctors would respond to the requests of the nurses, but would not spontaneously approach the nurses about the program. The nurses did not want to spend the time or energy to set up a system to link with the out-patients. However, Ann and the acting head nurse were beginning to open the lines of communication:

> Beth: We used to think it was something that they [the doctors] really wanted. Something they thought a lot about. I think that they do think it's fine. They are admitting people for the program. But they don't think about it a heck of a lot. As long as we do it and don't cause any problems. If we approach them with a problem, they will support us. I don't think that it's a real important thing to them. They're too busy and concerned about a lot of things. It's something that they don't have to be too concerned about on a day-to-day basis. Whatever we want to do with it is fine, it's our program. I think it would be nice if we could have more communication with the doctors about the kind of patients to bring in. I think quite frankly that they're having a problem with their relationship with out-patients. There's a lot of people that could benefit from the program and that we could accommodate because we have such small groups. The doctors see these patients all the time. We have no way of getting in contact, of finding out who they are. It's only through the doctors that we could. But then you don't want to spend the time or the energy to do it. The doctors have a walk-in clinic here. They have some receptionists who we've never had much contact with. Ann is trying to get something set up. The acting head nurse has been down there. We're trying to get lines of communication going with them and start working together. It's ridiculous that we're not. It's quite insane. It's a waste of time and energy on both parts. Ideally we should be working closely with the doctors about which patients should be coming and and we should be working closer with the nursing staff in the clinic (Interview 19, Excerpt:4).

Beth was wondering if problems were developing over the staff nurses' perceptions about the planning activities in which the teaching nurses were engaged. Beth was feeling somewhat guilty:

> Beth: I think there's problems with some of the staff nurses. They see us with the opportunity to take time off or come to the office. They know we're getting paid for it, they see us in our street clothes, they see us wandering around, they don't see us writing furiously the whole time we're here. They think we're having a good time and probably think, "Oh, they're having coffee all day, that must be nice and we're here working." There's some feeling of animosity or something. The other girls that are with the program are defensive. They're not overly concerned. You have to be very careful because the staff nurses don't understand what's going on. I feel guilty if I'm not moving constantly when I'm out of uniform (Interview 19, Excerpt:5).

Beth had some ideas of how the morning should have been planned and knew how she was going to prepare herself if the nurses ever got together as a group for another planning day:

> Beth: An agenda should be written for the day so you're using your time properly. People should do some background research. They should read what other people have done, read a bit of theory on how such things are done. Then when we come in, we can take the information and do it. The day should be planned ahead of time. You don't just come in and start. Before our next planning day comes, I'd like to talk to Ann and Marg and Ruth and say, "This is exactly what we should do in the morning for so much time and then if we aren't getting anywhere go on to something else." That way we won't waste so much time (Interview 19, Excerpt:6).

Beth did not know for sure when the four nurses would meet again:

> I: Are you booked to have another planning day?
> Beth: The opportunity will be there if we can get our times together. We're not on the same rotations. It's possible that next week there might be one day which would be good.
> I: At this point it's not planned. You don't know that on a specific day next week you will come in to do planning with Ann?
> Beth: Not specifically. We narrowed it to Wednesday or Thursday. I'll have to talk to her again.
> I: What does that depend on?
> Beth: It will depend on the other girls because I'm working nights and those are my days off. For me those are the only days that I'm willing to come on.

> I: You'd be coming in on one of your days off and that would be with pay?
> Beth: Yes (Interview 19, Excerpt:7).

Marg had worked with the total group of four teaching nurses on Wednesday (she had arrived late) and with Ann on Thursday. She was thoroughly frustrated with the planning and development activities of the last two days. Her first words on walking into the interview room are reported in their entirety:

> I: Tell me your story.
> Marg: I'm tired, I'm just really sick of it. I still don't know what I'm here for. We haven't really had a purpose. We haven't put down our objectives for the days that I've been working. I'm just going along for the ride and just feeling like a tit on a bull to tell the truth, the eighteenth one, the one that shouldn't be there. These people come in and talk to us and I don't know really what Ann wants of them or what they're doing there. We had two gals - we had an in-service gal today and somebody yesterday who is also in-service I think, I forget - but you know Ann wants advice. I'm not sure of what she's asking. I don't know what's going on. So finally, just before you came in, I said, "What am I here for, what can I do?" I've been sort of sitting around and she'll ask a question or two and I'll answer it. We did a bit on the assessment but it's not organized and it wasn't in headings. I don't feel that we've accomplished a hell of a lot. We were just starting back on the assessment thing when you came in. I figured the day was washed up anyway, so forget it. I might as well come in here and chin wag for a while. Yesterday was just awful. I was late. Beth got in at noon. We started to work I think about 2:00 o'clock, or about 1:00 o'clock. Also, you know, we're not pulling together because we don't know what we're supposed to be doing. No blame on Ann, but to utilize us, I think she should (and I'll have a chat with her before I go home) set out some plan. Because I was thinking about it and, maybe I'm too money oriented, but four people's salaries for 8-hour shifts is a hell of a lot of money to waste doing not very much (Interview 20, Excerpt:1).

Marg did not know prior to the development days what she would be doing. She thought the nurses might be organizing the modules and working on the pre-test and post-test. She thought the days would be organized. She had not expected to be discussing nursing care plans and trying to talk to the doctors:

> Marg: I didn't know what was going to happen or what we were going to do. I thought we'd be organizing the objectives and context of the different modules or whatever we're calling our sessions. I guess we are, but it's going from this to this and she's [Ann] talking about a care plan and I can't follow her, I can't read her mind, because I didn't know beforehand what we're doing. I was hoping we would get the pre-test and post-test done. We've been looking at a whole lot of information, getting a little bit done I guess. We got a few points down for assessment. But it has been hodge podge. I didn't know we were going to be looking at nursing care plans. That was just thrown at me today. I had no idea that there would be another care plan for these patients. That's why I was a bit negative. I would like to know where we're going, what is the plan here? Yesterday was horrible. We were waiting for Ann to come in and talk to the doctors about the teaching program. I wasn't aware that we were going to be talking to the doctors about the teaching program. It didn't pan out [meeting the doctors] because we didn't come in to rounds. We were waiting until the tail end of rounds and by the time we walked around, the rounds were out. Now it's on for next week. Ann thought that the acting head nurse had arranged this with Dr. S. She hadn't. It wasn't too well planned (Interview 20, Excerpt:2).

Marg wanted to establish some short-term goals. She thought that the day's activities should have been planned in advance:

> Marg: There's no purpose. There's no goal. We need a short-term goal, what we're going to accomplish this morning, this hour, or at least today. Before we ever came in yesterday we should have been reading the articles and come in armed and ready (Interview 20, Excerpt:3).

Marg was not sure what the girls from in-service were doing although she did gain some helpful information. She thought the whole exercise was phoney:

> Marg: Having the in-service girls here has been adding to the confusion. Maybe it's helping Ann because Ann knows what she's doing. Although the girl today - what's her name? I forgot it already - gave us this one super article from the American Journal of Nursing. We'll get a lot of information from that. I find it so phoney. I'm just not into this world. Like when this girl came, it's probably completely irrelevant - my feelings you know.
> I: What were they like when she came?
> Marg: We were out to lunch, I came back a little late because I stopped at the bank. The girl was there. I thought the girl was extremely bored, that's the facade she was giving us. I walked in and sat there and smiled and didn't know what to say for 20 minutes. I thought, "I can't take it, let me out of here."
> I: Does the room have anything to do with that?
> Marg: Oh, it's horrible [The room was small]. Next week we're going to try and get away from here (Interview 20, Excerpt:4).

Marg had been afraid of the development activities. She did not have a degree, she did not know what was expected of her, and Ruth and she did not get along:

> Marg: I was afraid. I don't have a degree. Maybe I'm starting to feel like I need more education. I've done modules and stuff in a supervisory capacity. I hadn't seen Ann before and I really didn't know what was expected of me. I was leary of it. Ruth and myself are, well - just sitting for a day with Ruth is difficult for me. Everything that woman ever comes out with is the opposite of what I would do. For some reason, we are just opposites. I knew it was going to be fairly difficult. Ruth wasn't here today, so that helped (Interview 20, Excerpt:5).

Marg described the group dynamics in more detail. Everyone had their own ideas. The two nurses with baccalaureate degrees, Ann and Beth, wanted things worded in a complicated way while Marg like simplicity. Marg was frustrated:

> Marg: Nobody seems to have the same thoughts on anything. Just to put down a sentence is frustrating. I think Beth and

> Ann, because of their degrees, want things worded complicated. I like simplicity. I want to put it down so that it's understood and forget the wherewithals and so on. To sit down and chat about a sentence and how it's going to be structured for five hours is frustrating. I know it has to be done. I find Ruth will argue just to argue. I'm seething. The group dynamics are not great at this point but we're just starting. It might get better. I doubt it. Beth and Ann are easy to get along with (Interview 20, Excerpt:6).

Marg felt guilty, as had Beth, about working in the office. She knew that the acting head nurse was busy and felt she should be out on the floor helping:

> Marg: Yesterday the acting head nurse was having an extremely difficult day with the regular ward clerk gone. The twit that is on is not helping her at all. I knew that. So that's been part of the old guilt. I've talked to head nurses about it for years, the old guilt of not working. I'm sitting around and I should be out there helping. The others [staff nurses] sat at the desk and we three girls sat in the back and the acting head nurse was trying to answer phones and go on rounds (Interview 20, Excerpt:7).

On the whole, Marg thought that the development activities had to be done, but she was annoyed with the process:

> Marg: It's a pain in the ass while you're doing it, but it will be an accomplishment later. I'm all for what we're doing, I'm just chafing at the process. It's the method, the way it's being done (Interview 20, Excerpt:8).

Marg, as Beth had been, was concerned about leadership. She thought she would gently give a little more direction to Ann about the next development day:

> Marg: Beth and I had a chat. She said the same thing. We'll have to sit down and help her [Ann] more. Ann is in charge but not feeling as if she's in charge. It's difficult because there really isn't a person in charge. [The former

> head nurse] gave it to Ann, but [the former head nurse] can't really do that when she left. If Ann doesn't take the reins, I'll gently push. I've been starting to do that this afternoon, like "What do you want me to do?" I'll have a chat with her and tell her to make plans so that the four of us can be productive. We've been almost totally non-productive for a time (Interview 20, Excerpt:9).

Ann was interviewed on the last day of the first planning and development week. Ann had worked alone on Monday refining the statement of philosophy and the goals and objectives for the program. She had spent the entire day on Tuesday in the out-patient clinic, observing the patients, the nurses, and the doctors, and assessing the need for the teaching program. Ann had concluded that the program could not be taught in the clinic but rather, that the out-patients should come to unit Y for the evening classes. She had also concluded that the nurses and doctors in the clinic did not do much patient teaching:

> Ann: Tuesday I was in the out-patient clinic all day observing what kinds of patients they were taking in and if there were any patients that would be suitable for the program. The nurses are anxious that we come down. They haven't got time to teach.
> They asked if we had any visual aids for them. I'll be taking the film down next Tuesday to show the staff. They said if it's suitable they'll ask to have it shown in the waiting room for the patients. I was in the waiting room with the patients several times. I would look through the charts and see who they were. Many of the patients I recognized from our unit.
> I: What were your impressions about the need for a program?
> Ann: We would have to trigger into newly diagnosed patients from the out-patients' clinic. Either talk to them down there about our program or leave information for them or ask the doctors to talk to them about the teaching program and have them come in as an out-patient. We have to go that route. We can't accomplish a lot of teaching down on that unit. It's very crowded and busy.
> I: You are saying that there was a need for a teaching

> program for those patients down there?
> Ann: Yes, because they were rushed through, they didn't get all their questions answered.
> I: What kinds of things were happening or what behaviors did you observe that told you that this program was required?
> Ann: I was reading the charts and I noticed that a lot of them were missing their appointments.
> I: Were there other things that alerted you to the need?
> Ann: They had a lot of questions to ask me once they found out that I was the teaching nurse.
> I: What was the relationship like between them and the doctor?
> Ann: They sat there and listened to what the doctor said. They didn't ask too many questions.
> I: Were you with them after the doctor left the room?
> Ann: Yes, I helped them to put their shoes on or boots or coats.
> I: Did they ask any questions of you after he left?
> Ann: They were in a hurry to go. I can't recall anything specific that they didn't have answered.
> I: How would what the doctor and patient were talking about compare with the kind of information that the patient would be given or seek in a session with one of you?
> Ann: The doctor didn't say anything about when to take the pills or to take them with any food or not food or milk. He didn't say anything like that. He said, "You're on three a day and you seem to be having a little extra pain, why don't you try four a day for a while until I see you next time? (Interview 21, Excerpt:1).

Ann reported on what had occurred during the brainstorming session on Wednesday with the other teaching nurses. They had discussed division of labor and had started to write some sections of the manual. Ann had wanted the three teaching nurses to react to the writing she had done. She felt the session was of benefit to herself but that the other nurses thought things had moved too slowly:

> Ann: This week we've met as a group for the first time. We had a good brainstorming session. We talked about dividing up the work. We started writing some of the sections. I felt it was good for me because I wanted to get their reaction to a lot of things that we were doing and things that I was planning. Some of the other members felt that nothing was happening that day. I know they felt like things

> were moving too slow. You know how committees go, they're kind of slow. There are times when you can't always get a lot done (Interview 21, Excerpt:2).

Ann talked about her role as leader. She had done most of the work prior to the development week and she needed some feedback from the other nurses. She did get good information from the group. But she did not think she had been a strong leader.

> Ann: I had done most of the work. I wanted to give them time to hash that over, tear it apart. A lot of ideas came from the group. What I hadn't thought of, the others did. That's why we need a group to work on this. I wasn't a strong leader. I didn't make out an agenda. But I feel that we needed the brainstorming and I went through, in my own mind, the things that I wanted to get done. Maybe that wasn't strong enough for the other nurses, I don't know. The next time, if we get together, we'll maybe have more of a definite agenda and say, "Now, let's tie in the loose ends" (Interview 21, Excerpt:3).

Ann described the group dynamics which had occurred on Wednesday. As leader she had attempted to involve the other three nurses in the development activities. She was concerned that Ruth and Marg might feel at a disadvantage because they did not have a degree and did not have experience writing teaching modules. She attempted to help them, and moved on to another topic when they got "bogged down":

> Ann: I worried about it because Beth and I are baccalaureate nurses and Ruth and Marg are not. I don't think Ruth and Marg are quite as familiar with the jargon or writing objectives as we were. I felt that Beth was more help. I expected that of Beth. I didn't want the other two to feel left out or inferior or somehow not as useful. I would try to make the climate informal. Sometimes I called the language "garbage language." I said, "It doesn't mean that much, but it's what's acceptable in nursing circles." I'd make light of it. They accepted that. They know that we have to do it this way to get approval for our program.

> Ruth, I think, had worked with objectives before. I tried to teach Marg the difference between goals and objectives. She saw it and said, "Thanks, now I understand." I think that was probably worthwhile, it takes a little bit of time. I guess we got off the topic. Writing isn't as easy as talking. I expected that. We'd get bogged down because we couldn't think of words or phrases. I would quickly jump to something else. I would say, "Let's leave that a while and work on something else." Maybe that's not the best way to do it. But I get bogged down myself, can't think of anything new to say. I helps to come back to it later (Interview 21, Excerpt:4).

Ruth had mentioned in her interview that while she saw development of the program as a co-ordinated effort between all the involved departments, it was her feeling that the rest of the nurses thought that the physiotherapy department and the doctors were not interested in communicating with the nurses about the program. Ann confirmed Ruth's fears when she described how the nurses had dealt with the description of the program during the Wednesday brainstorming session:

> Ann: We wrote a description of the program. We decided there was no way that physio and O.T. was our responsibility. We can't possibly write a description of a program for them. We're not sure that we can write the program for them. We're not sure that we can write the medical one either. We're going to do the nursing one and we're not sure about the others. We were trying to talk to the doctors during the rounds but they were too busy and in a hurry and really not interested (Interview 21, Excerpt:5).

Ruth had reported that the nurses missed talking to the doctors on Wednesday because of poor planning. Ann now gave her version of what had happened. The doctors were in a hurry to leave the unit, the chief doctor hadn't been there, and she didn't think the doctors were interested anyway:

> I: You say that you tried to talk to the doctors? What did

> that involve? How did you go about trying to talk to them?
> Ann: We asked them for time at the end of their rounds when they were in the conference room.
> I: Do they go into the conference room after they've finished rounds on the unit?
> Ann: Yes. They spend at least an hour or more discussing the patients and treatments.
> I: What happened then?
> Ann: They were all in a hurry to go and Dr. [Z] wasn't there. He didn't come that day and Dr. [T] didn't really want to hear about it without Dr. [Z], so he said, "Come in next week." We may do that.
> I: I get the feeling that you don't hold out a lot of hope.
> Ann: No. I guess we thought that we should be getting them to even read our material, and O.K. it. I don't think they'll do that and I don't think they're interested at all. They don't think it's necessary, I have that feeling (unless Dr. [Z] comes through and is interested).
> I: What kinds of things give you the indication that they don't want to get involved or aren't interested? Are you able to be more specific?
> Ann: We always have to prod them to get a program going and to bring in patients suitable for the program. It seems that every once in a while they might think about it and say "Well here's somebody for a program." Usually we don't have enough people. [The acting head nurse] will have to get after them and say, "Look, we've got two people here who we admitted who should be in a program. How about bringing in some others? Do you have anybody else?" Sometimes they'll find a couple of others they'll want to admit and sometimes they don't (Interview 21, Excerpt:6).

Ann confirmed, as had the other three nurses, that plans had not been made for time for the next planning day:

> Ann: Hopefully we'll have another day, the four of us.
> I: Has that day been decided?
> Ann: No.
> I: Do you think there might be a day next week?
> Ann: I don't think next week, not until the following week (Interview 21, Excerpt:7).

At the conclusion of the interview Ann remarked that she "felt some responsibility for the program" and that she "felt somewhat inadequate as a leader" (Field notes: January 13, 1984).

Ruth and Ann worked together every day during the second development week. Ruth was interviewed at the end of the week. She reported that she had planned what she was going to do during the week, had arrived at the office at 6:30 a.m. (two hours ahead of Ann) on Monday morning to get herself organized, and had taken more of a leadership role in identifying what work Ann and she would undertake during this second development week:

> I: When you left last week did you know what you'd be doing when you came here this week?
> Ruth: I had my own plan.
> I: When you came on Monday did you operate with your own plan or did Ann come in with a plan of how she thought the week might go?
> Ruth: I had the advantage because I came at 6:30 and she didn't come until 8:30. I had two hours work done before she ever got here.
> I: So you were already in the room and working?
> Ruth: I was all spread out by the time she was anywheres near.
> I: What happened during the first hour after Ann arrived? What kinds of things did you do?
> Ruth: I stopped and had coffee. I told her what point I was at in my lecture. We talked about that. She talked about her own objectives for the week and what she wanted to have completed by the week. We talked about the nursing care plan and I said, "Why do that? I already have one done that I did for Nursing Grand Rounds." We discussed that. I said, "That's something you can put aside." We polished off the philosophy, read it over. We had some doctor's comments about it and we had to do revisions. We worked on the goals and objectives. We worked on the role for the program and the role of the team members, and that's basically what we did. I said, "I am going to work on this and you do whatever you have to do. We'll confer, but let's do our own thing." I did a little role-changing. I have trouble with that and I have to watch myself because I'm a great one to take over and say, "Hey, this is what has to be done and let's not procrastinate about it" (Interview 22, Excerpt:1).

Ruth and Ann talked to each of the doctors about the program. The doctors were willing to help the nurses. Ruth explained how the meetings with the doctors were arranged:

> Ruth: I approached them on my own between last Wednesday and this Monday to see if they would be willing to meet with us for ten minutes during rounds before they got into their discussions of the patients. I didn't say any more than just meet with us. They said, "Yes," they were more than willing. Once I had approached them, I sat down with Ann and said, "Look, we're going to meet them on Wednesday. Now we must have it planned out." I said, "Their time is valuable and we can't be taking up a half hour of their time. This has got to be done in ten minutes." Ann just about fell off her chair. Then we were down in the out-patient clinic on Tuesday (we went to see if there were any patients that should be in the program and to see how it actually ran. We also ran the film for the nurses down there and I'm giving the pharmacology lecture next Tuesday morning to the nurses), and the ward chief stopped us and said he couldn't meet us on Wednesday because he's leaving on a trip for three weeks, but he had a few minutes right then. So we had a chat in the hallway, but it was very good. Then yesterday, Wednesday, one of the other doctors came in before rounds, sat down on a chair and we had a great discussion. The other one came by and said, "Look, I'll drop in a little later." He came after rounds, so we talked to them all individually and they were all more than willing to help in any way. They read over the philosophy, the goals, the framework, and a description of the program. They're interested, they're willing to read over any materials that we write. Ann was shocked at the doctors' reactions, she was very surprised that they were willing. I felt good about it, I really did because my fear was taken away (Interview 22, Excerpt:2).

Ruth then discussed her feelings with Ann about the negative attitudes of the teaching nurses towards the doctors:

> Ruth: I told her my true feelings of last week and how I felt about that. Last week I let it ride, but I decided to push the issue when there were only two of us here. I knew if there were only two of us that things couldn't get bad. I told her I was concerned last week that these negative attitudes were a hold over from when [the former head nurse] was here and that people were trying to carry them on when the source wasn't here to aggravate the situation anymore. See I worked for all these doctors five years ago. I know them. What I told her was that based on our discussion last week (when we were all here as a group) I felt that their

> [the nurses'] understanding and perception of the doctors' roles and ideas of the program was that teaching was needed but as long as somebody was doing the teaching they [the doctors] really didn't care what was being taught. I said, "Now you must know from talking with the doctors that they're very interested and that the philosophy that they teach themselves is the philosophy they want to come out of the program. She agreed, but she didn't think before that they [the doctors] actually cared what the philosophy was as long as there was a program that taught something about [the chronic illness]. She thought it didn't have to be specific to their [the doctors'] philosophy. We had a great discussion. I don't think Ann really comprehends that the doctors just stopped by and that they are willing to help. I felt the other nurses were way off in left field with their assumptions that the doctor's weren't interested (Interview 22, Excerpt:3).

Ruth went on to explain why some of the divergent thinking was occurring. She knew she had a personality conflict with one of the teaching nurses:

> Ruth: Part of the problem with this whole group is that one of the girls and I have a personality conflict. You work on it all the time but it's far from smooth, and it will take years. So in the group of four, it is more difficult. I can work one-to-one with Ann with no problems and we've had a good week, we've accomplished a lot (Interview 22, Excerpt:4).

Ruth reported that this second week of development had been much easier than the first because she knew what she had to do and she was working in concentrated periods of time. However, she had concluded that a module could not be developed in one week:

> Ruth: It's easier this week because that's all I have to do. That was my assignment for the week. It was like having an assignment of patients out on the floor. I knew that I was going to do pharmacology. You just go at it and get it done. It's much easier to apply yourself instead of, "Oh well, we'll give you two hours here and four hours there and six hours somewhere else and a 12 hour day there." This way I can have it set up and fresh in my mind. You start

> thinking along a line, and you know the things to look for as you're reading along. It's easier when your power of concentration is in one place. But a module can't be written in a week. I don't care, I have applied myself this week. I really have, and I'm not going to make it (Interview 22, Excerpt:5).

Ruth reported that she was learning a great deal of new information as she developed the module:

> Ruth: The things you discover, you pick up little extras. See when I started teaching the program in the summer, I tried to use this book [points to a reference book] and it was too deep, but now that I've done a lot of reading, this book makes sense. I have a vast library of nursing books at home. I'm sure I could go through my degree without having to go to the library. I'm looking deeper for other things and I've changed quite a few things (Interview 22, Excerpt:6).

Ruth described one particular example of how her discovery of some new information about a drug was leading to a change in the protocol on unit Y regarding the particular drug. She wanted to know why the doctors did not know about this information and expected to get her hands slapped for raising the issue:

> Ruth: I picked up in the clinic yesterday that they gave shots without waiting for the blood results. I had read that the blood and the urine should be tested and the results read before the injection was given. The doctors didn't realize that. Also, due to the relocation, the lab and the clinic are now farther apart and they don't get the results back so quickly, so they just go ahead and give the injection. A build-up of this drug can be very dangerous. So we've added this need for blood results to our protocol on the unit. The information is going to be posted on the unit, and I'm also taking it to the clinic. It has to be approved by the doctors before it goes anywhere. I know they're going to slap my hands, but I want an explanation. I've dug up the dirt, now I want to know why they're not doing anything.
> I: And how do you plan on handling that kind of a situation?
> Ruth: Oh well, you know, when they question me I'll ask them why they're not doing it. Have they done further research

> and found that it's not necessary?
> I: And you anticipate that this kind of a dialogue will go along quite smoothly and be accepted by them?
> Ruth: Oh, yes, because I have a good professional and personal relationship with them all (Interview 22, Excerpt:7).

Ruth described how she developed her module on medications. She had determined that her module would have three parts, a patient teaching section, a section containing in-depth information for the teaching nurse and the medical staff, and a section about the instructional aids. She wanted to produce a thorough, complete module which would enable any nurse to learn about all the medications connected with the chronic illness and enable that nurse to teach the patients about those medications. Her module would contain very detailed technical information:

> Ruth: My unit for teaching the patients is complete. What I'm working on now is a teaching unit for nurses and medical staff, any medical staff that want to use it. This is a pre-empt to the patient teaching unit. I've gone into great detail with each drug, into all of the chemistry, the pharmacology, exactly what molecule it works on. It's more at a nursing level than at a patient level. The patients don't need to know a lot of this. They need to know the signs of what to look for and what to report to a doctor, but not all the complications. This section is so that someone like you can come in, read over this material and with two or three days preparation or a week, learn all this information. It is condensed in one area. Look at this one drug here. I go into how it affects the renal function, the hepatic function, the cardiovascular function. I go into everything you should be looking for when you give this drug. So when the nurse goes in to lecture, she should have a good understanding of what happens when a patient takes that drug. Even if the nurse has just read this section she'll be able to think back and say, "Hey, that information is here," when they ask her a question. It's just like an actual pharmacy lecture. Everything that anyone ever wanted to know about every specific drug that I can find through many sources. Then there'll be another section that goes along with the actual teaching unit. That will be about the

> instructional aids or audiovisual aids that I used in teaching. There'll be a format as to how I present the lecture and give out the handouts. It should be relatively simple for someone to pick up that module for the teaching unit, review it, go in, and give the lecture. The information will be at their fingertips. It won't be like I did before, scurry through all the information and write down as much detail as I thought I could remember, because I just didn't have time (Interview 22, Excerpt:8).

Ruth explained how she had formulated these ideas about developing a module. She thought she was developing an easy module because it contained more technical information than some of the other ones, and she thought that having taught the class and having answered patient and staff questions about the medications had helped her in the development of this module. She also identified some information that she would like to see included in the quackery module:

> I: Did you find it difficult to know how to write a module, and to identify what to put in it? Was that a concern of yours?
> Ruth: It is a concern in a way. I'm not as concerned as if I was writing up one of the other modules, in that a lot of my material is very technical. You can't flower it up, you can't use those great and wonderful words that we used in philosophies and goals and objectives. Those things have to be worded very carefully so they are taken in the right connotation. I haven't found it as hard to write this lecture as I would have writing about quackery. I hope with the quackery lecture that they include the history of quackery. I think it's important that some of the history as to how it got started is included. I think probably having to give this lecture without having a module in front of me gave me a lot of preparation as to what I wanted in the module. And all the questions the patients and the nursing staff have asked has helped (Interview 22, Excerpt:9).

Ruth was asked about how her thoughts on what should be included in the modules were communicated between group members and about how decisions were made:

> I: Now you've stated some things that you would like to have included in the quackery module. Someone else is preparing that module. How will you go about deciding among youselves what does appear in the module? What happens among the group members so that you get your ideas to the person who's doing the quackery module?
> Ruth: Well, subtlety. The other day when we were altogether, I mentioned, not directly, but said, "This has to be in depth and we have to take our time. We can't rush and do an incomplete job just became someone set a time limit on it. If we've done the job to the best of our ability, there's no reason that we have to be done by the 27th of January, it's not possible" (Interview 22, Excerpt:10).

Ruth had made some attempt to solicit suggestions from the other staff nurses about her module:

> I: Have the nurses offered their concerns and suggestions to you about things that they would like to see included in the module that you're working on?
> Ruth: No. I told them what I was doing. I had it planned for a while. I asked anybody if they had other questions, and no one seemed to (Interview 22, Excerpt:11).

Ruth reported that the staff nurses were asking questions about the development week. They wanted to know if the teaching nurses were producing anything. Ruth related this incident in general to an ongoing power struggle in nursing between diploma and degree graduates, and in particular to the response of the staff nurses to the former head nurse who had advanced education and pushed education down their throats. However, according to Ruth, the staff nurses thought the program was important:

> Ruth: There's a few vibes coming through about this week.
> I: What kind of vibes?
> Ruth: Subtle comments like, "How's the coffee party in the office going? Have you done anything? Are we going to get anything out of this?" I can reply "Yes," because my module contains a lot of extra information for them. There's a real

> power struggle between degree people and just R.N.'s within the hospital. It's more evident on [unit Y] than I've ever known it before. I think it's due to [the former head nurse] having advanced education and really pushing education. Some of the staff nurses are not interested, will never be interested, have no intention. Some of us are teetering, we don't know if it's worth it or not. There's been a lot of pushing about writing being important and it got shoved down the wrong throats. At the moment we had trouble with writing goals and objectives and criteria. They [the staff nurses] think the program is important. Once a program is finished and running a specific time, they'll think its okay (Interview 22, Excerpt:12).

Ruth, after completing the second week of development activities, worked one week of nights and then left for a six-week vacation.

Ann continued with development activities during the third week. She worked with Marg on Monday and with Beth on Tuesday. She was interviewed on Friday afternoon, the last day of the planned development time. Ann talked about the outcomes of the planning and development period. She had not accomplished as much as she had expected. Part of the manual had been sent to the typist. Beth and Marg had not finished their modules. They had not taken as much development time as had been planned. Marg was doing some work at home. Ann and Ruth's modules were almost completed. The nurse from the research and development department had been reading the material, but had been ill and was behind in her work:

> Ann: I can't say that I've accomplished all that I wanted to. Part of the manual is at the typist's. Part of it is down in research and development being read by the nurse there. She's been ill for a couple of days this week, so she says she's behind. The other girls are behind. They didn't take as much time off these three weeks as they'd hoped. They are still writing on it next week. I've been revising mine and it's nearly ready for the typist. Marg and I were working on the first unit which was the overview of the

> disease. She's working at home this weekend and it should be ready for typing next week. Things don't happen as fast as I would have liked (Interview 23, Excerpt:1).

In spite of the slow downs, Ann reported that a number of good things had occurred because of the development activities. In addition to the completion of part of the teaching manual, Ann reported that the nurses had made contact with the doctors, the out-patients' clinic, and the rehabilitation department and that a yearly schedule for the program had been drafted:

> Ann: Other than writing the manual (which I am very pleased about); contacts with the doctors, and spending time in the out-patients' clinics are very profitable and are some good developments that came out of those times. The nurses in the clinic are very receptive to us coming down and spending time with them and with the patients. Ruth and I and Beth have been there. We spent time with the patients, talked with the doctors and showed the film, and gave lectures to the staff. That's been very good. Through getting in touch with the doctors there, we've set up interviews for meetings with them here. They'd stop by the office [the doctors], we've explained the program to them, and they're 100 percent behind us. We've brought in a new development, suggesting that we have a program running once a month, starting the second Monday of every month. We drew up a schedule and they approved it. They said "Great." They were very happy about it and I have told physio and O.T. about this and they said, "Great, sounds like it's a good idea" (Interview 23, Excerpt:2).

Establishing a schedule meant that doctors could now plan to bring patients in from the rural areas when a program was being conducted:

> Ann: The doctors go out of town to the different cities and towns. The patients out there would like to come to the teaching program and they have been coming. The doctors will now see this as a time that they can bring the patients in from out of town. The doctors like this idea. They say, "Now we know where we stand with the teaching program." Copies of the schedule will be sent to their offices and

> there is a copy in the clinic. We may even send copies out to some of the clinics in the rural areas (Interview 23, Excerpt:3).

Ann thought the positive response of the doctors to the program was an important outcome of the development period:

> Ann: It felt like all of a sudden there was more support behind us, that maybe we were doing something that was worthwhile. That was especially needed from the doctors. These interns and resident doctors seemed to be more receptive. I spent time explaining the program to them. It's nice to know that when they are sitting in rounds, they say, "This patient is here for the teaching program and will stay for another two weeks." They won't just discharge the patients because they need the bed for somebody else. They are seeing it as an important part of that patient's treatment (Interview 23, Excerpt:4).

Ann did not confirm Ruth's report that the staff nurses were somewhat upset with the teaching nurses during the development period. In fact, Ann thought that the staff nurses were supportive and helpful:

> I: Are there other areas of support that you feel good about this week besides the doctors?
> Ann: Yes, there are. The nurses on the floor have been coming to me and saying, "Have you got time to talk to so and so? We have a new patient who seems to be denying her illness and doesn't want to talk about it." I spent considerable time with the nurses. It's been good. They're seeing this as part of the nursing care now.
> I: Did they ask any questions about what it is that you've been doing this week or suggest that it must have been nice to be off for three weeks? Any of that kind of undercurrent?
> Ann: No. Not at all. They're quite supportive. I usually catch them when they're sitting at coffee breaks or lunch breaks. I have them read over the material. I get good feedback from them. They're quite impressed with some of the stuff and say, "Well, this is really nice, you've really written that well." They've been part of it. I thought it was important that they be a part of the program (Interview 23, Excerpt:5).

In addition to the outcomes of writing part of the manual and making contact with the other people and departments, Ann reported that the teaching nurses had developed an assessment form and that the staff nurses had helped with development:

> Ann: Some of them [staff nurses] helped with the assessment forms that we've developed to use on the [chronic] patients for the program. They liked it. They said, "We should have this for all of our patients." There's one sheet about activities of daily living and the nurses thought this was a good idea for all our patients. We never had anything like this before. We'd just talk about it on the ward (Interview 23, Excerpt:6).

Ann had conducted a trial run on the use of the assessment forms. The nurse was to hand the form to the patients and the patients were to fill out the form themselves. She concluded that the section on emotional status should be open-ended, that the stress section should be revised, that the patients would need some help to begin to fill out the form, and that the nurses should check back to see if the patient needed help:

> Ann: We chose this form here. It's one of many we looked at. It was very simplified. The patients can fill it out themselves. I've used it on this group of patients, as a trial run. Already there are changes we should make.
> I: What kind of things need changing?
> Ann: The emotional status section has to be changed. I think it needs to be open-ended. Leave that section blank and let them write in their own words. We don't get anything when they're checking "yes" or "no".
> I: The patient will fill this out on his own?
> Ann: Yes, we're going to try to give it to them.
> I: What other things did you pick up from the trial run?
> Ann: We have to give them a little more help. We should go through it first before we leave it with them, and maybe check back to make sure they're checking the right column. We should zero in more on stress, ask them to perhaps list a couple of events in their life that brought on an [acute

stage] (Interview 23, Excerpt:7).

Ann reported that the nurses had begun to develop a pre-test for each teaching module:

> Ann: We're still developing a pre-test for each specific teaching unit. We're making it fairly simple, about six or seven questions. It would take only five minutes or less for them [the patients] to go through it (Interview 23, Excerpt:8).

Ann talked about ideas for program expansion which had been discussed during the development week. Dr. [T] had suggested the possibility of allowing patients of doctors practising at other hospitals to come and take the program:

> Ann: Dr. [T] suggested that we send material over to doctors at other hospitals, inviting them to send patients over here for the teaching program. They would be admitted under Dr. [T] or one of the specialists here (Interview 23, Excerpt:9).

Ann mentioned that a patient from another unit in the hospital was taking the program which had started on Monday. She saw this as another aspect of the program expansion but reported again on the need to have the patient referred to the program by the specialist. The physiotherapist had identified that this patient needed the program:

> Ann: We have one patient coming from another unit. They are very co-operative in getting him here all the time. We're pleased about that. It's just a matter of checking with the area supervisor to see how we should go about doing this. There is one problem. The doctors feel that the in-patients from the other part of the hospital should have a referral to this unit.
> I: How did you find this patient?
> Ann: Physio found him. Physio referred him because he was coming down to physio. He's not our patient, but he's an old

> patient of one of our doctors. He was in for chest problems under another doctor. We'll have to make it clear to the other units that if they have a patient who they think would benefit from the program, would they please send a consult to this unit (Interview 23, Excerpt:10).

The nurses continued to try to figure out a way to allow out-patients in to the program. The problems centered on the billing procedures of the physiotherapy department:

> Ann: We would like more patients to come from the clinics. There's a problem with that. We haven't worked out the details of the out-patients yet. To come as an out-patient, they have to have the prescription for therapy from the doctor to participate in the entire program. So far physio and O.T. are not willing to give their lectures. We're meeting with physio and O.T. next Tuesday morning at 8:00 o'clock. That's something we're going to have to work out. See, some of the physio's lectures take place down in the therapy room. They don't all take place up here on the ward. Physio wants to be funded. They have to bill Provincial Health Care for the patient (Interview 23, Excerpt:11).

In addition to reporting on the positive outcomes of the development period and the plans for the program expansion which the nurses had discussed, Ann also reported on some aspects of the development period which could have been improved. The nurses had only managed to meet together for one day, the room had been too small, getting material typed was a problem, and the nurses had not completed their modules:

> Ann: I think development would have been better if we had been able to schedule the other nurses to come in and if we had a better place to work (this is quite small). The other teaching nurses were tired, they were working full-time. It's not easy to take time off the unit and it's not easy to come in on your days off. This is a problem that we've had to work out. I can't blame anybody. It's just part of the

> picture.
> I: I thought the other teaching nurses were to be taken off the rotation.
> Ann: Ruth got five days off the rotation. She spent the five days with me.
> I: Was she replaced on the unit?
> Ann: She was replaced for two days on the unit and the other three days were her days off.
> I: Why weren't Beth and Marg replaced?
> Ann: Beth was on nights. It was hard to replace her because she is working with a group of nurses who are new. Beth was one of the senior ones on her rotation. Beth didn't push for it. She felt that it was more important that she put in her nights and be in charge. Therefore, she's going to still be working on her teaching module this next week. Marg came in. She got replaced for maybe two out of the six days. She still has work to do. She was tired. It's hard to get up and come in our your day off. Those are problems. I wasn't going to complain about it because I knew it would happen. We don't have any real deadline. We can extend it for another week or two if they want to work on it. I worked on the preliminary part of the manual. It's pretty well finished and my module is just about ready for typing. I've accomplished what I wanted to. I could have done more writing on the other units. I think the nurses who are involved should do it. Also, the typing seems to be a problem. It's the director's secretary who's doing the typing. She's putting the whole program on the hospital computer. I guess that is fine, except it comes out in very small print. I was hoping it was going to be a nicer print job. This seems to be the route we have to go. We may go to outside sources to print the patient booklet. We haven't worked on that yet (Interview 23, Excerpt:12).

Finally, Ann described her feelings about the development period. She had learned some public relations and communication skills, and she had learned that she would have to be assertive with the physiotherapist. She had been recognized by the doctors, had been asked to write an article for the Nursing Association Newsletter, and had been recognized by nurse researchers from the hospital research and development department and a faculty of nursing:

> I: What has happened to you personally during the three

weeks?
Ann: Besides becoming exhausted? It's been very different. I'm not one to sell myself. I can usually sell something else, like good nursing care or quality assurance. This program is a big part of me. I feel that when I'm promoting this program, I am promoting myself. That was hard at first. I think I became pretty good at the P.R. work. I started down in the clinic with fear and trembling. The doctors didn't even know me. They knew that I worked on the unit, they didn't know my name. Now they know my name and what I do and why I do it. I think they've come to know me and possibly respect me and my work and they've approved of the writing that I've done. That was good. The P.R. work, making contacts, and learning how to communicate was a big change for me. I realized that I went ahead of myself one step. I took the doctor's suggestion and printed this yearly schedule without conferring with physio and O.T. That was wrong. I should have called a meeting immediately and said, "This is what the doctors would like, and is it alright if I draw up a schedule?" They [physio] heard it first from the doctors. I sort of wanted to go that route because if they heard it from me first, they would have said, "No, it won't work." They did hear it from the doctors, and they were surprised. They probably accepted it better. I still think it was cowardly on my part to go that route.
I: Have you had any direct contact with physio and O.T. about the schedule?
Ann: Oh yes, I had to talk fast and really sell it; sell it as if it was the doctor's idea, which was a kind of sneaky and underhanded way to do it.
I: Did it work?
Ann: Oh yes. Physio questioned it. They said, "What if they bring somebody in from a rural area and there isn't a teaching program on? Aren't you going to run one?" I said, "The idea is that the doctors are not going to bring that person in from the rural area until it's time for the next teaching program." They said, "Oh I see, well, that sounds like a great idea." I think they're receptive to it. That was one way of learning. I've got to bite the bullet, I guess, and face them. Some of the other things that have happened to me personally is I have an invitation to write an article for a nursing journal.
I: How did that come about?
Ann: It came about at a wine and cheese party for a visiting speaker. I was talking to the editor. She was very interested in it. And one of the girls on a faculty working on research has stopped by a couple of times. She's been good at helping me, especially with the assessment forms. She talked to me about how to gather materials for research, and set up the material. She wanted to know how I was

> doing. Different ones in the research and development department of the hospital have talked to me and asked me how things are going (Interview 23, Excerpt:13).

Ann had talked to the President of the funding Association during the development period and was going to meet with her and provide a progress report on the program:

> Ann: I've talked to the President [of the funding Association] twice. I have my letter ready to give her with our new timetables and our proposals for expansion of the program. I'm going to see her tomorrow. I'll give her all the material. They're having an executive meeting on February 9th, so she wants a full report then (Interview 23, Excerpt:14).

On January 23, 1984, Ann meet with the President of the funding Association and presented her with the following letter. In the letter, Ann confirms that the nurses appreciate positive feedback from the patients and that the nurses have identified areas for program expansion:

> Dear Mrs. ______________,
>
> As coordinator of the [Chronic Illness] Teaching Program of (hospital X], I wish to give you a report of the activities of the program in 1983.
>
> The nurses on unit [Y] in [hospital X] became involved in the program about one year ago under the leadership of [the former head nurse]. A teaching program was developed with the physiotherapy and occupational therapy departments with the purpose of helping [chronically ill] patients better manage their disease. Four nurses have been teaching in the program this past year and all have expressed positive feed-back and appreciation from the patients who participated in the various classes. I am enclosing a description and time table of the program which may be of interest to you and your members.
>
> On behalf of the staff in the [teaching] program, I wish to

thank the Association for the funds and support you have provided to make the program possible. Your funding has paid for nurses and therapists to lecture to 30 patients as well as family members. The three week program was presented six times in 1983.

The [hospital] has been very supportive of the program and has recently made it possible for the teaching nurses to have time off ward duties to write a teaching manual. The director of nursing, and the [area supervisor] have both been instrumental in providing time and resources and consultants for us in this project. It is our aim to provide a high quality program to [the teaching] patients that is comparative to other teaching programs at the [hospital]. As we progress and improve the education services to [the teaching] patients, it is our hope that the program will become a permanent part of the treatment and nursing care to [these] patients in this hospital.

We have plans for expanding the program in ways that may help us serve a greater number of patients this year. Tentative plans are:

1. To offer the full program each month beginning the second Monday. The physicians have indicated that they would like to have specific dates for admitting patients who are likely suitable for the program. This would be especially helpful for out-of-town patients to plan ahead for their hospitalization.

2. To offer the full program to out-patients from the out-patients' clinic, and help those from out-of-town to find reasonable and close-by accommodation.

3. To offer the program to patients [with the chronic illness] on other wards of the hospital who are in for other reasons than [this disease]. This would be accomplished by advertising the program through various communication channels in the hospital.

Apart from the program at the hospital, the teaching nurses have all indicated to me that they would be pleased to participate in teaching in your new office when you get settled in it. Now that our teaching manual is being completed, we are expecting other nurses on unit [Y] to also become involved in the program and consequently would be available to your association from time to time.

Thank you for your interest and support in our teaching project on behalf of [Beth], [Marg], and [Ruth]. I am looking forward to continued communication and association with you and your members in the coming months.

Sincerely,
[Ann] (Document 13).

Reaction of Teaching Nurses to the Development Period

Ann, Beth, Marg and the acting head nurse were interviewed after the completion of the development activities. Ruth was on an extended holiday.

Ann was interviewed 1-1/2 weeks after the development period had ended. The investigator had arranged the interview with Ann, but forgot to inform the acting head nurse of the interview. The acting head nurse was perturbed that Ann was leaving the floor to be interviewed. The field notes written after the interview explain why:

> February 8, 1984
> Today I forgot to check with the head nurse for permission to interview Ann (last three weeks I haven't had to because nurses were off floor and working in the head nurses's office). I arrived to find the head nurse rightfully perturbed because she had a meeting at 2 p.m. (my interviewing to start at 1:30 p.m.) and had not been notified that Ann would be off the floor. Conducted interview and then apologized to the head nurse. She was very understanding and commented that it was just that sometimes Ann forgot she had other responsibilities on the floor in addition to the teaching program (Field notes: February 8, 1984).

Ann reported that three of the four teaching modules were almost finished. Beth was still developing her module on quackery. During the development period, the nurse from the research and development department told the teaching nurses that the modules should really be called teaching units. Throughout the remainder of this reports, "modules" and "units" are used interchangeably:

> Ann: Marg has finished her teaching unit on the overview of [the disease]. Ruth has just about finished proofreading her huge unit on pharmacology. She's gone on holidays. Beth's still working on her quackery. I think she's on days off working on it at home. She thinks she'll be finished next week (Interview 24, Excerpt:1).

Ann did not know whether the modules were similar in terms of format and depth of content. She had not looked at the modules:

> I: What are your feelings about the three modules that have been developed?
> Ann: The information in them?
> I: Yes, and . . .
> Ann: I think the information is quite broad and would give a new nurse a fair amount of information she needs to prepare herself.
> I: Are the modules similar?
> Ann: I haven't looked through them.
> I: I'm thinking of the way they're designed, the format, the amount of material that is in them, and the depth of the content that is in each module.
> Ann: I can't say. I haven't gone through Ruth's yet so I wouldn't want to say until I have it read through (Interview 24, Excerpt:2).

Ann was having problems getting the manual typed. She previously had been told she could use the area supervisor's secretary. Now she was directed to use the director's secretary. The secretary reported that she would not have time to type the entire manual:

> Ann: I'm still having a problem with typing. I was referred to [the director's] secretary because the director was away. [The area supervisor] thought that the director's secretary was not too busy. I took some material down to her. She put it on the computer. This is what comes out. I'm not really too happy about it. She can't put things on separate pages. It all runs together. I'm going to have to go down and talk to her. I hope to get down there today. There's another

> problem. I thought that this wasn't very much typing. She asked me how much more. This wasn't even all of the preliminary stuff. She hasn't even started with the units. I said there would be ten times as much, maybe more. She said she couldn't do it, she didn't have time.
> I: What happened then?
> Ann: I told the area supervisor about it today. That's all I know.
> I: I thought the area supervisor had a secretary you could use?
> Ann: She does, but she doesn't type on the computer. The other problem is that [the area supervisor] has never let me use her secretary. For some reason she doesn't want me to take stuff to her secretary. So I never have. I haven't given her anything to type.
> I: So you may be running into a problem with getting this information into a typed form?
> Ann: Maybe, yes.
> I: Did the supervisor say she'd get back to you on this?
> Ann: I said I was going to get back to her this afternoon. I don't know if she's here or not. It's hard when I'm working with patients and I was the only nurse on the floor for over an hour. The others all went to lunch and I had an aide with me. It's not that we're busy. The patient load is not really heavy. But you know how it is, the little things take as much time as major things (Interview 24, Excerpt:3).

During the development period, the teaching nurses had prepared a description of the physiotherapy and occupational therapy portion of the program to be included in the manual. Ann had taken these descriptions to the physiotherapist and occupational therapist and told them to react to the material:

> Ann: I gave physio and O.T. their description of the program. I told them to read through it and make any changes that they wanted. They haven't given it back to me. They said they hadn't finished writing it yet. I talked to them this morning. I said, "Can you please have it to me within the week." They said they would (Interview 24, Excerpt:4).

Ann gave a summary of her feelings about the development period. Development was a slow process. The bureaucracy in a hospital moved slowly. As a staff nurse she felt powerless. She felt that the nurses had to fight for everything they got:

> Ann: I felt really down last week. I'm feeling better about it now. I realize that you can't produce these things overnight. There's a lot of loose ends to tie up. I know what needs to be done. I'll maybe get at some of it myself. I guess I'm able to wait and see what kind of help I get from the hospital in finishing up the writing. I'm waiting for the nurse from research and development to bring back material she was proofreading for me. She hasn't contacted me. I tried a couple of times. She was never in. I left messages and she never phoned me. She's supposed to phone me at 2:00 o'clock. I thought, "Well, if that's her attitude, I'll just bide my time for awhile." I think that this is one of the problems at the staff nurse level. I really do. We're powerless. I have no power to say to anybody, "Look, I want this typed, I want this proofread, I want this printed." I haven't got any power to do it, so I sit and wait. I think we've had to fight for so much. Fight for a day to work at it. It does seem like a few extra odds were thrown against us. I know the bureaucracy of this hospital. I've been around hospitals enough. It's a slow process to get things done. It doesn't help to get all worked up and angry at people. I suppose I could stamp my feet and get really angry but I don't think that's the route to go. It will come. I don't know. Do you have any suggestions? (Interview 24, Excerpt:5).

At the end of the interview Ann was asked to describe her feelings about being interviewed. She felt alone and that during the interview she could talk to someone who understood:

> I: What does taking part in an interview like this do for you in this process? Does it do anything?
> Ann: It helps to talk to somebody about it. I feel that I can talk to you and tell you these things and you understand what I'm talking about. I don't feel I have anybody else I can talk to. I think the other girls think that I should somehow have power to go and demand things (Interview 24, Excerpt:6).

After the interview, the investigator began to wonder how she would analyze and report the research methodology that was emerging as the study progressed in addition to the findings:

> February 8, 1984
> After interview with Ann. How am I going to code, categorize and report, in addition to the analysis and findings of the data, the procedures that went on in this study? For example, today, I'm thinking that maybe I should interview the doctors whereas one month ago, I had decided not to. This is the snowball sampling effect (Field notes: February 8, 1984).

Beth was interviewed two weeks after completion of the development period. She had not finished developing her module and did not have the energy to do so:

> Beth: I was only in for 1-1/2 days during the development period. I still have some time left. I haven't finished my particular lecture. To tell you the truth, at this moment, I don't have the energy (Interview 25, Excerpt:1).

She talked about what the development period was like. She thought that the nurses were disorganized and had wasted time. On the whole, Beth thought that a number of good things had been developed. However, she was losing her enthusiasm:

> Beth: I felt we were disorganized. I wondered if we were wasting time and about how much we'd get done. I thought it was great that we had the opportunity to do it, but I didn't know how we'd manage it. I do think that it could have been managed much better. I think that we wasted time. They got a lot done. Marg finished up her thing. It would have to be edited a bit and typed. I can't remember if Ruth finished. I know she was working awfully hard before she left. She had volumes of information and I think some of it might have to be edited. It was good. She went into detail. That will all have to be typed. Ann got a bunch of things completed. We'd gone over and over criteria for admission to the program 'til I was sick. It shouldn't have been that hard. All those little details were finally typed. So they're

> finished. The descriptions of each part were all done. That was good. I feel like, "Yes, those things are done. That feels good. That's all finished." For my part, I fell down and I felt guilty. Ann is a lot more enthused than I am right now. I can in theory get enthused. But when it comes to spending time, I'm just so tired (Interview 25, Excerpt:2).

Beth thought she might be losing enthusiasm because she was thinking about leaving, she wanted to get on with other things in her life, and maybe she just was not stimulated by the program any more:

> I: Have you any idea why you're losing enthusiasm?
> Beth: Oh, I suppose if I really wanted to find reasons I could think of things. I don't know. I think it could be that one does have personal reasons. I've been thinking about things, like I want to leave. I want to get other things going. Or it could be that you talk about something so much that after a while it doesn't turn you on the same way. I don't know (Interview 25, Excerpt:3).

When probed further, Beth questioned whether anybody really cared about the program. Not enough patients were being admitted for the program (a program was taught as development activities were being completed), and it was hard to collect follow-up information about the effects of the program. She wondered if teaching on a one-to-one basis might not be just as good:

> I: Does it have anything to do with (and I'm just putting this forth for speculation for you to say "yes" or "no" or "not at all") the idea that either 1) the program doesn't make that much difference anyway, or 2) that putting all that work into the program doesn't make that much difference?
> Beth: It could be partly, because you start to wonder who really cares? Does anybody really care? How many patients are benefitting? We're having problems, right now, getting patients in for the program. That makes you think, "Well, gee, what for then? What are we doing?" You do it and you don't know if it's really going to make all that much difference? Will the amount of information we've giving really help anybody or won't it? Couldn't we just sit and

> talk with people who need to be talked to informally? I think that it is possible to find out about a difference. But we aren't able to follow people up afterwards. We discharge them immediately after (Interview 25, Excerpt:4).

The investigator continued to probe about collecting follow-up data on the patients. The investigator had speculated earlier (Tables 6.2 and 6.3) that the teaching nurses did not know what follow-up data to collect or how to collect it. The following dialogue with Beth reveals this speculation to be true. In addition, Beth confirmed that the nurses knew very little about developing a teaching program:

> I: Or is it you don't know what to look for?
> Beth: It could be. That would probably be a lot of it. We don't know.
> I: I'm just speculating, I don't know.
> Beth: Because it's sort of intuition and a lot of little things. I suppose we think well, maybe that patient got something out of it because he seemed to participate a lot or something. I don't know.
> I: What if while you were planning, someone had handed you a list and said, "These are the kinds of outcomes you look for when you deliver a program like this." What if somebody sat down with the group and said, "Let's take a half an hour here and identify the kinds of behaviors that you think will indicate that the patients are learning? Is that a mindless exercise or is that the sort of thing that you felt that you needed?
> Beth: Oh, I'm sure that would have helped. I'm sure.
> I: I wonder about that because you said at the beginning of the interview that part of the frustration was the disorganization of not knowing how to manage it.
> Beth: Yes, definitely.
> I: Is that the kind of thing you were thinking of or in addition to other things?
> Beth: Yes. It would have helped if we had ever seen what anybody else had done. If we had guidelines. Just simple things. Knowing how to write. Knowing how to formulate objectives. Understanding principles of teaching, learning and presentation of small and large group things. Just information on how to work in the system. All those things. There's a 100 things that could've helped. None of us have very much expertise. To think that we wasted so much time! The amount that we have done ever since the whole thing

> started is almost ridiculous. When you think of the kind of complicated assignments that you get done in school in a matter of a few weeks under pressure, or a couple of months! This was ridiculous. I really think so (Interview 25, Excerpt:5).

In addition to information about how to develop a teaching package, Beth thought the nurses should have been given more information about group work, about how to obtain resources, and about the process of planning:

> I: If someone were to say to you that next week you were going to start planning this teaching program and they wanted a list of things that you want help with, what would you say?
> Beth: I would like to see packages of practical material, which are different than patient teaching material. Like how to organize group meetings, plan agendas, how to get your hands on resources (like typists), how to raise money, how to even speak. We're all doing our own thing. Whatever we've learned in the past.
> I: Do you know how you would like that kind of material presented?
> Beth: That's hard. I don't know if I'd like someone to give a seminar. I don't know if it would be helpful to send people out to some sort of larger community based something somewhere. I don't know where you attend lectures on how to do these sort of things. Maybe it would help to have someone come in and work closely with us for a few days and say, "This is how people have done this in the past. They've made a long term time-line and month-by-month and week-by-week. They've organized themselves according to who does what so you don't overlap, you don't waste time and you do something always on a specific day." You make sure that things are done by a certain time and set yourself these small goals. I don't know. If somebody - yes, I'm just sort of thinking and talking - if somebody came through, even spent a day, just a day, sitting and chatting and saying, "Here's an outline, this is how to make your job easier. These are people that you can talk to. This is the kind of route you take to find out." Because within every institution and every hospital there are ways of going about getting hold of these people so you don't hit and miss and try. You know overall, we just didn't know and we could have used help. A time-line would have been good.
> I: A time-line?
> Beth: Yes. All those goals. Even the day-to-day ones. I

> don't want to criticize the girls because I know they tried hard and I didn't do anything compared to the amount of work they did. But coming in the morning saying we'll do a bit of this and after an hour changing and doing a bit of something else and finally two weeks later finishing a one-page thing that should have taken you a half an hour of concentrated work! That's what I call inefficient and a waste of time. I don't know, I think it takes time to learn how to brainstorm, too. Even when we did that, you can waste a lot of time brainstorming. You can learn how to do it well together and people can tell you how to brainstorm properly (Interview 25, Excerpt:6).

Beth talked about what the leadership was like during the development period. According to Beth, Ann was enthused but was not an expert leader. Beth thought that the leader should be from within the group but perhaps could have been trained by an expert from outside of the group:

> I: Some of the things that you've mentioned make me wonder about other things. How would these ideas be implemented in your situation? Did you think that you had a designated leader? If not, then my question is how as a group did you decide who the leader was?
> Beth: When [the former head nurse] was here, we sort of thought of her as the leader. When she was leaving, she asked Ann to be co-ordinator of the program. For one reason, Ann was most enthused and she's probably the one who would stay around and carry it out. That's true. She is the most enthused and she is trying to carry it out. But I don't think that she's got leader qualities, characteristics. I don't think that she knew. I think she's still learning. That's great experience for her and that's great to grow. But for our purposes, it would have been great if we had somebody who knew and who could've done all those other sorts of things. Get somebody in to help us. Somebody who knew that whenever you're undertaking any project, you go and you find help to do this and that. Ann is definitely the leader, but in a way she's still responsible to the floor and it's so . . . I don't know.
> I: Would it have been easy for anyone else in that group to take over the leadership of this particular planning session and do the things you were talking about?
> Beth: No. I don't think any of us could have done it very well. There wasn't anybody that we had available, unless we

> brought somebody from the outside. We didn't want to do that - it had to be one of us. So you take what you can get.
> I: How could it have been done differently?
> Beth: You can pick a leader and then train that leader. You say, "This is how to be a good leader, this is how you find help for your workers, and this is how you get something done." You train the leader and then that leader goes and does all those things for you.
> I: So someone from the outside could have trained one of you to be a leader?
> Beth: I think so. But any leader is better than no leader. It did help us to have some guidance, somebody who was holding it together (Interview 25, Excerpt:7).

Marg talked about what the development period had been like for her. She had been frustrated because she didn't know what she was supposed to do. She decided to do her development work alone at home. She was concerned about earning her pay, about whether what she produced was good enough, about being conspicious working in the office, and about working out of uniform. She felt better working at home:

> Marg: I was in with Ann. I was so frustrated I wanted to cry. I didn't know what she wanted me to do. I took two office days at home. I didn't get back with the others. I wrote up on [the disease] itself, the treatment of the disease, the physiology of it. I really enjoyed doing that.
> I: Why did you find it was better at home than here?
> Marg: I could do it on my own time. The only pressure for me was that I kept wondering, was I doing enough to earn my pay? I knew I was doing the hours. Was I doing it good enough? I was flying by the seat of my pants. When I actually got into it and got down to it and did a pre-test and a post-test, I really had fun with it. I didn't just spend two days at it, I spent four hours a day for about a week. But I had this worry about whether I was doing it good enough, just because I was being paid for it, because it was regular time. Once I got over that, then I did enjoy it. So that was good. Coming in and being out of uniform, I always felt like I stuck out like a sore thumb. I didn't feel part of it. That element was gone, when I was at home. It was much easier to work at home (Interview 27, Excerpt:1).

The acting head nurse talked briefly about the development period. She confirmed the report of Ruth and Beth that some of the staff nurses were disturbed by the development activities, particularly by the fact that the teaching nurses were off the unit working in the office:

> Acting head nurse: We did have a few little hassles when the girls got office time. A few jealousies. I just said, "If you get involved in it, then you get the perks. Then you get days off to do office time." I didn't really harbour on that one too long because I thought it was a waste of time (Interview 26, Excerpt:1).

Ann had worked on development activities during one week in December, 1983, and three weeks in January, 1984. The four nurses had worked together for one day in that four week period to plan and develop the teaching program. Factors continued to emerge which appeared to influence the change process, in particular the planning and development period. The factors are discussed in the following section.

## Discussion of Planning and Development

By the end of the four week development period, two sets of factors had emerged from the data which appeared to have influenced planning and development of the program. Factors which appeared to facilitate the planning and development activities and factors which inhibited planning and development are listed in Table 7.3. The factors are now discussed.

## Factors Which Facilitated Planning and Development

Listed in Table 7.3 are seven factors which emerged from the data and appeared to have facilitated the planning and development activities.

Need for materials production and program expansion. The teaching nurses recognized and confirmed during implementation that two major areas of the program needed to be developed. First, the nurses identified the need to produce program materials. While the teaching nurses had recognized very early that the program was needed and was relevant, they now, after initial implementation, could not continue to deliver the program until specific components of the program were developed. They reported that detailed teaching modules were required. Pre-tests and post-tests needed to be designed. Some form of program evaluation should be undertaken. A nursing assessment procedure, or sheet, or format was required. The philosophy, goals and objectives of the program and the criteria for patient selection had to be clarified and refined. A booklet needed to be developed for the patients.

Ann in particular viewed the program as a totality and identified many components which required further development. Ruth was not motivated by developing philosophies and objectives and criteria for patient selection, however, as indicated in the data, she vigorously took up the challenge to develop a teaching unit on medications. Beth and Marg were thoroughly frustrated by the process of development but as Marg reported, "It needed to be done and I even enjoyed it once I got going." This recognized need for materials production motivated

Table 7.3

Factors which Influenced Planning and Development

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1.1 Factors which Facilitated Planning and Development

- 1.1 Need for materials production and program expansion
- 1.2 Observation of teaching nurse outcomes
- 1.3 Experience with implementation
- 1.4 Support of administration
- 1.5 Expert consultation
- 1.6 Models of other teaching programs
- 1.7 Recognition

2. Factors which Inhibited Planning and Development

- 2.1 Leadership
- 2.2 Planning for development
- 2.3 Antecedent conditions
- 2.4 Knowledge and experience
- 2.5 Resources
- 2.6 Multiple realities

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the nurses to take part in development activities.

Second, the evidence indicates that the nurses identified areas of the program which they reported should be expanded. They felt that many more patients should be taking part in the program. According to the nurses, patients should be coming into the program through the out-patients' clinic and from other units in the hospital. Members of the Association and patients from the rural areas should have better access to the program. Three new modules (diagnostic tests, pain control, and diet and nutrition) should be taught. Finally, the nurses should take over the community resources lecture from the social services department. This recognized need for program expansion seemed to have motivated the nurses to take part in planning and development activities.

Teaching nurse outcomes. The nurses were able to observe outcomes of the development activities for themselves. First, the nurses, Ruth in particular, demonstrated that they had gained new knowledge during the development period. Second, the acquisition of new knowledge had led to a change in unit protocol. Third, the two diploma educated nurses recognized the possible merit of advanced education and began to question their former reluctance to pursue baccalaureate education. Fourth, all four teaching nurses reported that while they were not happy about the process of development, they were pleased with the products, specifically the teaching units, which three of them had developed. Finally, the nurses were pleased that they had made contact with other personnel and departments which had an impact on the program (the out-patients clinic and the doctors). Overall, the ability of the nurses to observe personal outcomes facilitated the development process.

Experience with implementation. Three of the teaching nurses indicated that it was more meaningful to become involved in development activities after having taught the program a number of times than it would have been to attempt developing program components before teaching the classes. While the nurses still had great difficulty with what they considered to be the ambiguous, abstract area of program philosophy, goals and objectives, they found it relatively easy and even fun to develop the specific content of a teaching unit after having taught in the program and having answered questions from the patients and staff. There seems to be little doubt that the involvement of the nurses in implementation was a factor which directly facilitated the activities of the planning and development period.

Support of administration. Nursing administration supported and, in fact, had initiated the development activities. The effect of this support on development activities became manifest in two ways. First, the support had a direct effect in that it was the director and the area supervisor who recognized the need for development activities and it was they who responded to the need and provided the necessary resources. It was the director who had read the teaching manual and recognized the paucity of developed program materials. It was the area supervisor who met with Ann and provided assistance to develop a plan for development activities as outlined in the memo of November 29, 1983. Required resources in the form of release time from the unit, experts, and typists were identified and were intended to be provided.

Second, the support had an indirect effect. Support of administration was seen by the nurses to be a form of recognition. In particular, Ann and Beth commented that they felt good that nursing administration were finally recognizing the value of the program, were recognizing the effort which the teaching nurses were expending on the program, and were providing support and resources for development activities. The show of administrative support for the program and of recognition for the efforts of the teaching nurses facilitated development of the program.

Expert consultation. The area supervisor had identified and made available to Ann, who was labelled co-ordinator of the teaching program, experts in patient teaching programs at hospital X. In particular, nurses from the in-service and research and development departments were identified as people with whom Ann should meet. The evidence in the data indicates that the teaching nurses benefitted from meeting with the expert nurses. Ann, in particular, saw other teaching programs written in modular form, saw samples of assessment forms, and saw pre-test and post-test formats for other programs. She talked with the experts about the process of program development in general, about how to go about developing statements of philosophy, goals and objectives, and about the components of a teaching unit. Ann and the other nurses became aware of relevant articles and textbooks which they could use in developing the teaching program. The nurses, who previously had described themselves as isolated from the rest of the hospital became aware of what went on in other units and in other teaching programs in hospital X. However, the other three teaching nurses did not appear to benefit from the contact with the experts as had Ann. Marg described herself as totally confused and did not know what the experts were doing, although she thought the article from a nursing journal which they had given the group was very useful. On the whole, the consultation with experts facilitated the planning and development activities.

Models of other teaching programs. Ann, the co-ordinator, was aware of a teaching program which was being delivered at another hospital. She obtained a copy of that program manual. Although she previously had some idea of what needed to be developed in the present program, she indicated that "the lights came on" when she saw the other program in print. An examination of Ann's proposed contents of the teaching manual (Document 12) revealed similarities to the teaching manual at the other hospital; it had become a model for Ann's program. In addition, the teaching materials from other programs within hospital X also provided Ann with ideas of how to develop certain aspects of the present program, in particular the pre-tests, post-tests, and nursing assessment forms. There appears to be strong evidence to suggest that the availability, although late in coming, of models of other teaching programs greatly facilitated Ann's development activities.

Recognition. When the last program of the Trial Run was delivered in November of 1983, the nurses reported that they felt alone, isolated and powerless. However, after Ann's first week of development in December of 1983, she reported that the acting head nurse was very supportive, that the doctors were supportive and interested, and that the head nurse in the out-patients clinic was very interested in the program. The doctors knew her name, knew what her role was, and thought her writing was of a high quality. The head nurse in the out-patients clinic wanted Ann to visit the clinic, teach in the clinic, and show the film to the patients in the clinic. Ann reported that this made her feel good.

The nurses in the in-service and research and development departments and the faculty of nursing recognized her, talked to Ann, asked her "how she was doing," and offered to assist her at any time. She was asked to write an article for the Nursing Association Newsletter. It was clear from the data that to Ann, these actions on the part of others toward her were a form of recognition and reward.

Beth also commented that administration now recognized and supported the program and it became clear in the data that to Beth this could be translated to mean that they also recognized her involvement in the program. There is strong evidence in the data to suggest that the recognition of the teaching nurses by significant others facilitated planning and development activities.

In summary, all seven facilitating factors motivated and encouraged the teaching nurses to stay involved in development activities. The teaching nurses came to unit Y on their days off to take part in the development activities and they also worked at home on their time off (with pay) to develop their specific teaching unit. However, all four nurses did not complete their assigned development activities or use their allotted development time. The nurses met as a group only once during the three weeks in January. On the whole, the four nurses expressed disappointment and frustration with the process of development because of certain factors that had inhibited planning and development.

## Factors Which Inhibited Planning and Development

As indicated in Table 7.3, six factors were evident in the data which appeared to have inhibited the process of program planning and development.

Leadership. According to the three teaching nurses, Ann did not have the necessary characteristics, expertise, or experience to be a good leader. Ann reported that while she felt responsible for the program she did not think she had been a good leader. The nurses indicated that they did not know what time to meet on the brainstorming day, that they did not have reading materials prior to meeting, that they had not expected to be discussing philosophy, objectives, and criteria for patient selection or to be meeting with the in-service nurse and the doctors, that they did not have an agenda, that they became "bogged" down in one area and did not move along to something else or in the case of Ruth, that they moved along too quickly and produced material of only a superficial quality, that they did not know how to develop the program materials, and that they did not know with certainty when they would next meet or what they would do when they did meet. They expressed feelings of confusion, furstration, and disapointment with the whole process.

The evidence indicates that the nurses liked Ann, applauded her for her enthusiasm and devotion to the program, and felt that she was doing the best she could under the circumstances. Although the nurses were not sure they could do a better job of leadership, they each quickly made plans "to help Ann "out" and "to do their own thing." The nurses never met again as a group after the "brainstorming" session.

Ann indicated that she felt she had let the nurses down. They expected more of her than she had delivered and they expected her to behave in ways with which she was not comfortable. Ann did not like to tell people what to do or to use a "heavy hand." She reported, "that is not my way." Ann's behavior indicated that she reacted to situations rather than proacted and that at times she was reluctant to make decisions and to act upon them. In addition, she did not think that she had the power to make the bureaucracy work faster anyway. Ann reported that she had learned a great deal during the development period about communication skills and realized that she would have to "bite the bullet" with the physiotherapist. Overall, it seemed that the development period was, in the words of Beth, "a growth period for Ann." However, it was abundantly clear that leadership was lacking during the development period and that this lack of leadership had a direct inhibiting influence on the development process.

Planning for development. While Ann, as leader, had made plans about what should be developed during the development period, there was no indication in the evidence that she had planned, nor that she had communicated plans to the other nurses on how to proceed with development activities. As previously mentioned, agendas were not made and distributed, the nurses did not receive reading materials nor did they know what to prepare for their first meeting, time-lines were not prepared, objectives for a given development time-period were not prepared, and the nurses did not know at what time to meet or when the next meeting would be. The nurses thought they would probably be developing their specific teaching units with related pre-tests and post-tests during the group meetings. Instead they met with the doctors and expert nurses, they visited the out-patients' clinic and they discussed philosophies, goals, objectives, criteria for patient selection, nursing assessment and nursing care plans. In addition, the nurses continued to work on the program during their days off. Plans had not been finalized to release the nurses from the unit and the nurses did not fully utilize the days on which they were released from the unit. As had happened with implementation, it seemed that plans had not been formalized for the planning and development period. This lack of planning clearly inhibited the development process as it had inhibited implementation.

Antecedent conditions. As noted in Chapter 4, antecedent conditions influenced the adoption stage of the change process. It became clear in Chapters 5 and 6 that antecedent conditions, in particular the existence of an old program and the control of one physiotherapist over the program, had influenced implementation. Evidence emerged in this chapter to indicate that four other antecedent conditions resulted in the nurses forming pre-conceived assumptions which had an influence on the change process, in particular, the planning and development stage. First, it seems that on-going conflict had existed between the physiotherapy department and the doctors. The teaching nurses thought the doctors should have more control over the physiotherapy department but that due to frustration with the department, the doctors had avoided the conflict and were just allowing the physiotherapy department to maintain control of the program and to control the kind and quality of care which the patients were receiving. As a result, the nurses, except for Ruth, did not think that the doctors were very interested in becoming involved in development activities, particularly in reading what the nurses had written. It was later confirmed in interviews with the doctors and the physiotherapist that a long standing history of frustration and conflict between the two departments did exist. However, the pre-conceived assumptions of the nurses were wrong. The doctors did exhibit interest in the development activities.

Second, the nurses reported that conflict had existed between the former head nurse and the physiotherapist. As Ruth said, "Those two can hardly stand to live in the same city." Except for Ann, the nurses, therefore, had a pre-conceived assumption that the physiotherapy department would not take part in program development activities.

Third, the nurses reported that they were aware of the conflict which had existed between the former head nurse and the doctors. The conflict seemed to be centered around the professional role of the nurse which the head nurse envisioned vs. the traditional dependent role of the nurse envisioned by the doctors. Due to the antecedent conflict the nurses did not expect the doctors to be very supportive of development activities. In the subsequent interview, the doctors confirmed that conflict with the former head nurse had existed. The conflict was centered on the role of the nurse and the educational level of nurses. The doctors could not understand why nurses needed advanced education. In addition, one doctor in particular viewed the former head nurse as being negative and using "blocking" tactics. As he said, "If I showed her a glass of water half-full she would say it was half-empty. If I said something was black she'd say it was white. We simply couldn't work with her." However, as previously mentioned, the doctors did support the nurses in the development activities.

Finally, Ruth reported, and the data supports her belief, that an undercurrent of negative feelings about the different educational levels of nurses on the unit and within the hospital existed. The investigator first became aware of the antecedent condition when Marg remarked to the investigator, "For a master's type, you're O.K." (Chapter 6). During the development period Ann was concerned that the two diploma nurses might feel left out and not useful. Both Ruth and Marg, the two diploma nurses, were frustrated with the abstract areas of development and began to feel the need for further education. Beth felt that valuable development time had been spent trying to teach the diploma nurses about philosophies, goals, and objectives. It seems that the perception of a difference in educational preparation and a real difference in educational levels did influence the development process.

Taken together, one can safely say that these four antecedent conditions, which led the nurses to make assumptions about others, did inhibit the development process.

Knowledge and experience. It has been argued that a lack of leadership and a lack of planning inhibited the developmental activities. Evidence in the data indicates that these two factors were linked to a third factor. The nurses lacked knowledge about and experience with developing a teaching program. Beth outlined in great detail the problems which occurred during the development period, as did the other nurses. The problem with agendas, time-lines, preparation, goal-setting, and brainstorming have been previously discussed, as have the problems with philosophies, goals, objectives, and criteria for selection of patients.

It seems that one can safely say that the nurses were suffering from a lack of knowledge and experience with teaching programs and the administration of the development process. The nurses did not know what components made up a teaching package, or a teaching program, did not know how to develop the components, did not know what administrative skills were required, and had little or no experience with the development process. In addition, the investigator began to question if the nurses had clarified for themselves what they considered to be the domain of nursing. It seemed that Ruth's unit on medications was to a large degree medical rather than nursing oriented.

The evidence indicates that the nurses required expert guidance in the areas of the domain of nursing, content development, teaching package and program development, and administration of development activities. None was forthcoming. This lack of knowledge and experience appears to have had a profound inhibiting effect on the development process. As Beth said, "We simply didn't know, we'd never done it before."

Resources. The evidence in the data suggests that two of the resources which were provided were not adequate and inhibited the development process. First, the nurses complained that the room in which they worked was too small for four people plus the occasional expert nurse. The evidence also indicates that the fact that the room was on unit Y had a detrimental effect. The nurses knew when the unit was busy and when the acting head nurse could have used their help. They were self-conscious of being on the unit out of uniform and felt that they were being judged by the other staff nurses. One can speculate that the development activities could have been better carried out off the unit.

Second, according to Ann, the typing resources were not adequate. She had expected to use the area supervisor's secretary; she could not do that. She expected materials back quickly, in proper format, and that a large amount of typing could be done. These expectations were not feasible and Ann felt powerless to do anything to remedy the situation. The inadequacies of these two resources had a minor inhibiting effect on the development process.

Multiple realities. As had been the case with the stage of implementation, the existence of multiple realities again emerged from the data as a factor which had an influence on this stage of the change process. The existence of multiple realities became manifest in three ways. First, the evidence indicates that each nurse had an expectation about her own role in development activities and the role of the others, in particular Ann. Ann expected teaching nurses to come to the development period prepared. She wanted to brainstorm and solicit information from them about her ideas for development. The other teaching nurses expected Ann to be prepared and to provide them with leadership. Ruth wanted to solicit reactions and support from the physiotherapist and doctors. The other teaching nurses assumed that the doctors and physiotherapist were not interested. Ann and Beth had not expected to spend time teaching Marg how to write objectives. Marg and Beth did not know what would happen during the development period. Beth thought nothing would happen and stayed home in the morning. Marg was confused and "sat and smiled a lot." Beth and Marg chose to do most of their development work at home. Marg and Ruth could not sit in the same room and get along and Beth found it difficult to concentrate in the group setting. Clearly, the nurses' expectations, needs, and roles kept getting in each other's way and in the way of development activities.

Second, the nurses had differing perspectives about the importance of development activities. Clearly, to Ann and Ruth, the development period should have had high priority. However, Beth and Marg both felt guilty about spending time on development activities to, what they perceived to be, the detriment of patient care. Marg wanted to be out on the unit doing "hands-on" patient care and helping the acting head nurse. Beth chose to be in charge on evenings rather than take part in additional development activities. The development activities appeared to be of high priority to only two of the four teaching nurses.

Third, the nurses each appeared to require different forms and amounts of recognition. Ann and Beth were both pleased that they and the program were finally recognized by the nursing administration. The impression that Ann was pleased by and required excessive amounts of recognition from others, in particular the doctors, the head nurse of the out-patients clinic, and the expert nurses was further reinforced during this planning period. Ruth generated her own form of satisfaction and did not seem to require much recognition from others. Marg did not seem to expect much of anything, particularly recognition, from anyone.

The argument has been made that each of the nurses had their own view of reality regarding expectation of themselves and others, the priority of the program, and the kind and amount of recognition which they required and received during the development period. It is concluded that the existence of these multiple realities did inhibit the process of development.

## Summary

Ann was involved in development activities for one week in December, 1983, and three weeks in January, 1984. The three other teaching nurses intermittently became involved in development activities during the three weeks in January. During that time the nurses met as a group for only one day. Specific program components, two teaching units and plans for program expansion were developed.

However, none of the nurses met their own expectations nor appeared to meet the expectations of each other during the development period. Development had, as had implementation, proven to be a complex undertaking which lacked clarity and prior planning. Seven factors emerged from the data which appeared to have facilitated the planning and development activities. These were:

1. Materials production and program expansion
2. Observation of teaching nurse outcomes
3. Experience with implementation
4. Support of administration
5. Expert consultation
6. Models of other teaching programs
7. Recognition

The evidence indicated that six factors had inhibited the development process. These were:

1. Leadership
2. Planning for development
3. Antecedent conditions
4. Knowledge and experience
5. Resources
6. Multiple realities

On January 23, 1984, the nurses delivered a program as the development period was ending. What happened during the period between January and September, 1984, when data collection ceased is documented in the next chapter. For the purpose of this study, the period has been called Implementation of the Planned Programs.

# CHAPTER 8

# IMPLEMENTING THE PLANNED PROGRAMS

## Introduction

It was reported in Chapter 6 that the nurses taught the last class, of what in this study has been labelled the Trial Run, in November of 1983. As was described in Chapter 7, planning and development activities occurred during December 1983 and January 1984. Between January 23 and February 3, 1984, the nurses delivered the first of the newly scheduled programs. The teaching nurses were interviewed during the implementation of the first scheduled program and continued to be interviewed until September 21, 1984, when the final interview of the data collection period was conducted.

During the period between January 23 and September 21, 1984, which for the purpose of this study has been labelled "Implementing the Planned Programs," other informants were identified and were interviewed. These included the acting head nurse (who was appointed to the position of head nurse), the former head nurse, the area supervisor, a second acting head nurse (replacing the newly appointed head nurse who took a five month leave of absence), the physiotherapist, five staff nurses, four doctors, and nine patients.

The results of the analysis of interviews with the newly appointed head nurse, the second acting head nurse, the former head nurse, the area supervisor, the physiotherapist, and one of the staff nurses, in addition to the four teaching nurses are included in this chapter. The results of the analysis of the interviews with the remaining staff nurses, the doctors, and the patients are reported in Chapter 9.

What happened as the nurses implemented the newly planned programs is presented in this chapter. As with preceding chapters, this one is divided into three sections. The events which occurred while the nurses delivered the planned programs are described in the first section. In the second section the factors which influenced this phase of implementation are discussed. Finally a brief summary is provided.

## Overview of Implementation of the Planned Programs

The events which occurred during the remaining nine months of the study period, as the nurses implemented the planned programs, are listed in Table 8.1. One program was delivered as scheduled once a month from January to September 1984.

The nurses taught three lectures during each program. Three of the lectures, the introduction, stress and quackery were delivered using the newly developed materials. Ann, Ruth, and Marg, each at different times, delivered the introductory and stress lecture. Beth did not complete development of the quackery lecture until June and the lecture was not in print until the fall. Beth taught the old quackery lecture until June when she resigned from unit Y and was replaced by a new teaching nurse. Between February and September, the medication lecture was taught by a pharmacist. Ruth was on vacation when the February program was delivered. Between March and September, she continued to refine the medication lecture and to teach the stress lecture. The nurses reported that as each program was delivered several old problems were resolved and several new ones emerged to

Table 8.1

Implementing the Planned Programs

| Time-line - 1984 | Events |
|---|---|
| January 23 - February 3 | . Nurses teach first scheduled program<br>. Physiotherapist delivers lectures during daytime<br>. Meeting of unit Y staff nurses |
| February 6 | . Program coordinator meets with Association president<br>. Association treasurer will not fund planning time |
| February 13 - 24 | . Nurses teach second program<br>. Pharmacist gives medication lecture |
| March 5 - 16 | . Nurses teach third program one week ahead of schedule<br>. One in-patient from another unit in hospital X attends program<br>. Funding problems continue |
| March 28 | . Program coordinator conducts a follow-up interview with patient<br>. Funding problems continue<br>. Teaching nurses paid regular salary<br>. Acting head nurse to take L.O.A. in May |
| April | . Nurses teach fourth program<br>. Two staff nurses join the teaching team<br>. Second acting head nurse appointed to fill in for the first acting head nurse |

Table 8.1 (continued)

| Time-line - 1984 | Events |
|---|---|
| May | . Fifth program conducted<br>. Sessions taught during the day<br>. First acting head nurse appointed permanent head nurse (second head nurse)<br>. Teaching nurses teach one class in out-patients' clinic<br>. Four month plan designed by second head nurse and area supervisor. Will be implemented in September<br>. More staff nurses need to be involved in the program |
| June | . Sixth program conducted<br>. Two staff nurses attend classes to be oriented<br>. Beth leaves<br>. Two classes taught during daytime<br>. Conflict continues with physio<br>. Second head nurse communicates with Association<br>. New teaching nurse teaches quackery |
| July | . Seventh program conducted<br>. New teaching nurse teaches quackery<br>. Meeting among second head nurse, second acting head nurse, and five teaching nurses<br>. Assistant coordinator appointed |
| September | . Eighth program conducted<br>. Five teaching nurses in program<br>. Second acting head nurse coordinates program<br>. Two original teaching nurses thinking of leaving |

take their place. What happened during the nine months is now discussed.

## Delivering the January Program

The first scheduled program was delivered between January 23 and February 3, 1984. Ann and Beth were interviewed about the program. Ann taught the introductory lecture and showed the film during the first program. She reported that it was "a good session." However, problems did exist, in particular with the Association and with the physiotherapy department.

In early February, Ann met with the President of the Association and presented the program report (Document 13, Chapter 7). Four problems had emerged with the Association regarding the program. First, according to Ann, the executive of the Association were disappointed that few patients, only 30, had taken part in the program during the previous year. Second, the Association wanted the program to be taught in the out-patient clinic. Ann did not think that the Association could afford to pay the nurses to teach in the clinic and she was sure that the hospital would not fund such activities because: ". . . the hospital doesn't feel it's important (Interview 24, Excerpt:1)." Third, Ann mentioned that problems had surfaced about funding of the time which the nurses had spent in December and January to develop the program. According to Ann: "The [Association] treasurer is most upset about it, so they're [the Association] having an executive meeting (Interview 24, Excerpt:2)." Ann felt the problem with funding was due to a lack of written communication outlining the development plans, in particular plans about funding and she did not think it was her job to do so: "I don't know if it was my fault. I didn't feel that it was my job. I didn't go ahead and request funds because I wasn't asked to (Interview 24, Excerpt:3)." Finally, the Association had received a request from the physiotherapy department to print a patient booklet. The Association had wondered: "How come you can't get together and make one booklet (Interview 24, Excerpt:4)?" However, Ann reported that the Association was pleased that the program would be delivered according to a schedule once a month, and that patients from other hospitals would be admitted to hospital X to take part in the program.

According to Ann, the physiotherapy department was again causing problems. They had changed their scheduled lectures from the evening to the daytime period:

> They have decided now, that they're not going to teach in the evenings. They can move all their lectures to the afternoon. They are not going to bill the Association. They can do it during working hours and they refuse to come in evenings anymore (Interview 24, Excerpt:5).

Ann was concerned that the patients would become overtired if they were not allowed to rest during the afternoon.

During the first scheduled program, Beth taught the old lecture on quackery as she had not completed developing the new lecture. According to Beth it was difficult to sit down while at work to complete her lecture. Nursing care on the unit took priority over teaching the program and developing the program for both the teaching nurses and the staff nurses. She estimated that she thought about the program only one per cent of the time that she was working on the unit. Beth suggested that one new lecture could be added to the program. She wondered if the patients needed some information about facing the prospect of dying. That, according to Beth would mean more development: "We'd have to start all over again (Interview 25, Excerpt:1)."

### Delivering the March Program

During March, the acting head nurse, Marg, Beth, and Ann discussed implementation. The acting head nurse talked about her reactions to delivery of the planned program. She confirmed that numerous problems and program changes continued to occur. The first problem concerned funding of the program. The acting head nurse had been sending bills for the nurses' time to the hospital accounts department which in turn was to bill the Association. However, the Association treasurer would only pay for teaching time, not planning and development time. In addition, the nurses were being paid two dollars per hour less than the agreed upon, but not documented, salary for teaching the classes. The acting head nurse felt that there had been a breakdown in communication between the executive and the treasurer of the Association and that she would have to meet with them to clarify the situation.

A second problem had arisen in relation to the proposed schedule of the planned programs. One patient had been admitted in early March who, according to the doctor and the patient, needed the program. However, the program was not scheduled to begin until one week later.

Both the doctor and the patient were upset with the proposed delay. Therefore, the physiotherapist, the nurses, and the acting head nurse discussed the problem and decided to teach a non-scheduled program. During delivery of the program, the patient became upset with the attitude of the physiotherapist and with what he considered to be rough treatment during therapy. He left the unit half-way through the program. The acting head nurse was upset. The physiotherapy department was upset. They had planned their yearly schedule around the program schedule, which in their opinion had already become: ". . . screwed up during the second program (Interview 26, Excerpt:1)." The acting head nurse decided to try to maintain the schedule as planned, although she was aware that: ". . . it's going to have teething problems and the doctors may continue to argue against doing it on a monthly basis (Interview 26, Excerpt:2)." She listened to the doctors' arguments, and countered that ". . . it can't be any worse than the way it was and it may be more organized this way (Interview 26, Excerpt:3)."

A program change had occurred which involved the pharmacy department who had requested that they be allowed to deliver the medication lecture. The acting head nurse agreed that a pharmacist should give the lecture:

> Personally, I would like her to do it rather than a nurse. She's a pharmacist. She knows it extremely well. I think we have to talk it over when Ruth gets back (Interview 26, Excerpt:4).

The acting head nurse also reported that she had not had any specific conversation since December with the director or area supervisor about the program, that a staff meeting was held in January but the program had not been discussed because the teaching nurses had not completed the necessary paperwork to present to the staff nurses, and that the hospital had finally advertised for the position of head nurse and that she would apply. In addition, she mentioned that Ann would be on holidays during April and that Beth was leaving the end of June. Two staff nurses had indicated an interest in teaching and would be oriented to the program.

Finally, the acting head nurse described her involvement in the program. Most of her time was spent on administrative activities related to the program, such as writing letters about the funding problem, fielding phone calls, and handling the "hassles". She felt that she had been by-passed in the communication which had occurred between Ann and the Association.

> There are some things she has done that I would have preferred if she would have spoken to me first. Like she met with the Association and didn't tell me. I would have liked to be in on that meeting. She wrote a letter to the treasurer and told him she was going to spend three weeks in the office and that got his back up. He probably didn't understand what she was doing. I'll have to meet with him and the two ladies (Interview 26, Excerpt:5).

During March, Marg reported on her involvement in teaching the planned programs. Marg identified some problems which she had encountered. First she had exchanged lectures with Ann and had taught the stress lecture. It was difficult and very stressful for Marg to teach from someone else's material: "I found it terriby stressful, it was absolutely gruesome! It's far better to do what you've researched yourself (Interview 27, Excerpt:1)." Marg wanted to talk to the other teaching nurses about her problems with the stress lectures.

Second, Marg did not know as much about the history of the patients when she taught the stress lecture, which was the second lecture, as she did when she taught the introductory lecture in which the patients each introduced themselves and gave a brief personal history. She felt at a disadvantage teaching the second lecture and thought that all the teaching nurses should attend the first lecture. Better yet, she still thought that there should be one teaching nurse to provide continuity of delivery.

Marg reported that some of the old problems continued to exist. She was still teaching after a 12-hour shift, she was not necessarily assigned to nurse the teaching patients, the staff nurses were still not interested in teaching the program, and nursing administration was not applauding the program. However, Marg reported that there was some positive outcomes. The patients continued to consider the classes worthwhile, the teaching nurses did discuss the program when they worked the same shift, and the acting head nurse was always supportive.

Beth was preparing to leave unit Y in June. She was losing interest in the program and hoped that the new teaching nurses who were young and were recent graduates would learn a lot and would be enthused. Beth was frustrated by the fact that she kept seeing patients with the chronic illness who really could be helped very little by the health professionals. She was not convinced that the program was making a difference. However, she admitted that she had never sat down with a patient and asked specific questions to gain feedback. Beth was frustrated by the fact that change: ". . . took such a long time to occur" and that ". . . so much politics was involved (Interview 28, Excerpt:1)."

She did not feel that nursing administration [the director and the area supervisor] could be counted on to really listen to the nurses or to follow through with required actions. She felt that administration did not care about the details unless it was in their own interest to do so.

Ann discussed the changes and the problems which were occurring as the planned programs were implemented. She had designed a form to collect data on who attended each class during each program. During March, an independent occupational therapist had attended a lecture. In February a patient from another unit in hospital X had attended the lectures. Ann had been filling out the form. She reported that the other teaching nurses knew about the form but had not been using it. Ann intended to use the form to provide the details for a quarterly report. According to Ann, the secretary had finally started to type up a file card for each patient which included the patient's name, address, a list of medications, a brief history, telephone number, and age. The information would be of assistance for patient follow-up.

Ann had phoned one patient: ". . . just for fun and to talk to her to get some feedback (Interview 29, Excerpt:1)." Ann had not planned in advance what questions to ask the patient; however, during the course of the conversation, she did determine that the program had contributed to a change in patient behavior. She planned to do additional follow-up phone calls: ". . . whenever I have the time (Interview 29, Excerpt:2)."

According to Ann, problems continued to plague implementation. Ann reported that as of March 28, 1984, the hospital had received no money from the Association and that the hospital was paying the nurses for teaching the classes. One of the doctors had been away for four months and had become upset when he returned to find that the programs were being delivered according to a schedule. Ann stated that he deliberately admitted three or four patients immediately for the program which resulted in program delivery being moved ahead one week. But Ann stated: "I don't mind, I understand men and doctors. I just don't raise an issue. I don't fight back (Interview 29, Excerpt:3)."

Another problem occurred when Ann attempted to work on program activities while nursing on the unit. According to Ann: "This is not acceptable to the acting head nurse or the staff (Interview 29, Excerpt:4)." Ann had tried to hand out the assessment sheets and to help the patients fill them out. Ann reported she was reprimanded by the acting head nurse:

> The [acting head nurse] says I've been sneaking around doing it. I was reprimanded. She said, "What you have to do [Ann] is come to me and say you need two hours or four hours to do this sort of work." Up until this point I didn't think I was allowed to have two hours or four hours for the teaching program. She seems to have had a bit of a change of heart toward the program and that it actually is a very important part of unit Y. I thought she considered it was something extra and so I never thought I could ask her for time (Interview 29, Excerpt:5).

## Delivering the April Program

The acting head nurse was interviewed at the end of April after the fourth planned program had been delivered. In mid-May she would be taking a leave of absence. Therefore, this was the last interview which would be conducted during the study period with the acting head nurse.

Changes and problems continued to occur during implementation of the scheduled programs. According to the acting head nurse, although it would be desirable to teach the program during the day, it was not realistic to do so at this time. One teaching patient was constantly down in the physiotherapy department receiving therapy at any given time during the day. Family members could not attend the day-time lectures. She reported that the pharmacist had tried to squeeze the medication lecture into the noon hour. The patients had to 'bolt down' lunch, go to the lecture, and be back in their rooms to go with the porter at 12:50 to the physiotherapy department. This routine was not satisfactory. The pharmacy lecture would have to again be taught in the evenings.

The acting head nurse reported that problems had occurred when the quackery lecture was given on Thursday evening of the last program week. Patients were often discharged on Thursday if the hospital needed the beds for emergencies and/or if it was a long weekend. This problem had occurred twice since the new schedule had been implemented in January: "We're only in April and already two quackery lectures had been missed. It's not very suitable (Interview 35, Excerpt:1)."

The acting head nurse identified a need to give the staff nurses feedback about the program. She had wanted the teaching nurses to present a program report at the January staff meeting. This was not done. A staff meeting was planned for early May. Ann, the co-ordinator, would be just returning from a month of holidays, so the acting head nurse would present a program update to the staff nurses.

It was necessary for the staff nurses to be knowledgeable about the program so they could answer the phone and give correct information to people who were inquiring about the program. According to the acting head nurse: "Some of the staff nurses don't have a clue as to what's going on. They're just not interested. They're afraid to be asked to teach and they don't ask any questions at all (Interview 35, Excerpt:2). Information about the program would have to be produced in a printed form. The acting head nurse had received phone calls from nurses at rural hospitals who wanted some printed information on the program to give their patients.

The acting head nurse had begun to make plans for continuation of the program. More teaching nurses should become involved in teaching so that eventually each nurse would come back to the unit only once a month to give a lecture. Hospital funding would be provided to allow the teaching nurses to spend a total of two hours per month on program paperwork. Documentation about the program activities (e.g., funding, teaching time, planning time, minutes of meetings) should be kept up to date. Such information would make it easier to deal with problems when they arose and to inform administration of the program status. Lectures should be updated on a regular basis. Program meetings should be held every two months. A report on the program should be a part of every staff meeting.

On the whole, the acting head nurse felt that progress was being made in the areas of program development and implementation. However, she felt that much remained to be done. She was "quite surprised" that so little of the program had been developed when she accepted the position of acting head nurse.

> There really wasn't anything there! The program did not exist. The girls were giving lectures from a couple of pages that had been handed over from the physiotherapy and occupational therapy departments. There was nothing organized (Interview 35, Excerpt:3).

She was also: ". . . amazed at how much power and control the physiotherapist and other resource people seemed to have around here (Interview 35, Excerpt:4)." The acting head nurse reported:

> I couldn't believe how little nurses were involved with a lot of aspects of patient care. It seemed that patients were forgotten in the mountain of administration and paper work that was done on the floor. The nurses should be involved in the all-round care of the patients (Interview 35, Excerpt:5).

Finally, the acting head nurse speculated about the motivation of some of the teaching nurses. According to her, it had been discussed quite openly on the unit, during program adoption, that some of the nurses joined the teaching program because they were in danger of losing their jobs during the period of budget restraint.

## Delivering the May Program

Ruth and the area supervisor were interviewed in May. Ruth had given the medication lecture to the nurses in the out-patient clinic. In addition, she had given the stress lecture twice and confirmed

Marg's report that it was very difficult to deliver a lecture which had been prepared by someone else. During May, all the nursing lectures had been given in the first program week followed by the community resources and medication lectures in the second program week. The pharmacist continued to give the medication lecture.

Ruth had made three observations about the program. First, the patients were not asking questions after the stress lecture. She thought a lecture on pain should be substituted for the stress lecture. The topic of stress should be incorporated into each of the lectures. Second, the patients were not asking as many or the same kinds of questions about medications as they had when Ruth gave the medication lecture. Third, the nursing assessments were not being done. Ruth thought it was time to do an evaluation of the program.

Ruth felt that rather than attempting to involve more nurses in the program, one nurse should be responsible for the program. She reported that conflict was occurring between the program co-ordinator and the acting head nurse, between the teaching nurses and the staff nurses, and between the area supervisor and the program co-ordinator. According to Ruth, the problems seemed to be caused by a breakdown in communication, by a struggle for power, and the fact that no one was taking responsibility for organizing the times to give the lectures or for organizing equipment required for each lecture. Ruth reported that the acting head nurse had been appointed head nurse and a second acting head nurse would "fill in" while the newly appointed head nurse took a leave of absence. According to Ruth: "If the number of nurses involved in this program does not diminish, the program is going to go under (Interview 38, Excerpt:1)."

The area supervisor was also interviewed in May. She discussed her expectations regarding the program, the problems and changes that had occurred, her suggestions and plans for continuation of the program, and what she, in retrospect, would have done differently during implementation of the program.

The area supervisor discussed her expectations: "I had expected to see a lot more developed (Interview 39, Excerpt:1)." She reported that: "I had hoped that at least consistent content was given to each of the individual patients and the patient's families (Interview 39, Excerpt:2)." She did not expect the teaching program to become a priority on unit Y:

> I have some concerns about what some people's values are, the importance of that program. I think it's very important but I don't want it overblown as that's the only thing that's important on that unit because it's not. That is one aspect of patient care of the unit. From the administrative side, I'm concerned for the total aspect. I would be very concerned if ever I perceived or I saw or heard someone else perceiving that that is the totality and that more emphasis is being given to that than some other aspects of patient care. So that part is quite important to me (Interview 39, Excerpt:3).

She had observed that Ann and Beth possessed good writing skills and expected that participation in the program was for them: ". . . a good reward system. We should give them positive strokes (Interview 39, Excerpt:4)." When she looked at what had been produced during the development period, the area supervisor reported she had expected to see more of the manual developed and that this expectation was not valid for a number of reasons. First, she was comparing the program to another one in the hospital which had taken ten years to refine. Second, these nurses were trying to work full-time on the unit and at the same time develop the program. Third, she thought that development, particularly writing, took time: "They need time to think about it. Writing takes a great deal of time. It's not everyday you can write (Interview 39, Excerpt:5)."

The area supervisor recognized that many problems and changes had occurred during implementation. Funding had become a problem area. She did not know where the money would come from to pay for the time the nurses had spent in development activities. She thought that miscommunication about funding had occurred between the program and the Association. Three reasons were possible. First, the head nurse had left. Second, the documentation about funding: ". . . could have been better (Interview 39, Excerpt:6)." Third, the acting head nurse did not know how much authority she had in these matters and did not know how much emphasis to place on program activities: "She wanted to prove that she could run the ward, give safe adequate patient care. Then she had this project on the side (Interview 39, Excerpt:7)." Finally, the area supervisor had not been involved in the program activities from the beginning: "Then for obvious reasons I had to become involved. I was picking up the pieces (Interview 39, Excerpt:8)."

In addition to recognizing the problems and changes which had occurred, the area supervisor recognized that changes continued to occur and that possible problems loomed on the horizon. First the new head nurse was taking a leave of absence and a second acting head nurse had been selected. The lack of a permanent leader on the unit would continue for another six months. Second, one of the teaching nurses was leaving and two staff nurses were joining the teaching team. They would need to be oriented and would need time to adjust to teaching the program. Third, the summer was coming which usually meant minimal staff would be available who could only provide basic nursing care on unit Y.

In light of the past problems and changes which had occurred, the changes which were occurring, and the potential for new problems, the area supervisor made plans for continuation of the program. A minimal amount of work would be done on the program during the summer: "Then, in September, we will make plans for the next quarter (Interview 39, Excerpt:9)." More staff nurses should be "incorporated" into the program: "It should be the responsibility of all the nurses in the group so they all have some sense of ownership (Interview 39, Excerpt:10)." Material should be produced for the patients: ". . . to take home and read at their own level. I found this was very important in [the other] program (Interview 39, Excerpt:11)." A time should be planned every day, when feasible, to discuss and work on the program. Consultants from the research and development department should be available to the nurses and utilized on a continual basis to provide: ". . . structured guidance (Interview 39, Excerpt:12)." A place, other than the head nurse's office, should be provided where the nurses could write. Library resources should be accessible. Finally, the area supervisor thought that the room in which the nurses gave the lectures should be: ". . . an appropriate setting and conducive to presenting the information (Interview 39, Excerpt:13)."

The area supervisor discussed what she, in retrospect, would have done differently during implementation of the program:

> I don't think there was *that* much more that could be done differently. Maybe we *could* have planned ahead of time, rather than later on, time to plan, what parts of the program to implement, and what parts of the program to write (Interview 39, Excerpt:14).

She would not have brought in the expert consultants earlier: ". . . unless the planning group thought there was some reason (Interview 39, Excerpt:15)." She would begin the program with four nurses who had volunteered and she would have: ". . . one co-ordinator who was responsible for organizing and planning (Interview 39, Excerpt:16)."

## Delivering the June Program

During June, 1984, the physiotherapist, the former head nurse, and Ann were interviewed. The *physiotherapist* discussed her own role and that of the department in the development and delivery of the old and the new program, the problems which had occurred, the possible causes for the problems, and how development and delivery of the program should have been conducted.

The physiotherapist discussed the *role* of the department in development and delivery of the program and explained how nursing had become involved. According to the physiotherapist, the physiotherapy department, she in particular, had: ". . . devised the whole program (Interview 42, Excerpt:1)." She had designed the sections of the program and the philosophy and had selected the people who would deliver the program. The old program was modelled on one from a hospital in another country and was to have a multidisciplinary focus. However, the rehabilitation department alone had delivered the program until the former head nurse joined the staff and the unit was moved to a different location. The physiotherapist reported that the former head nurse wanted the nurses to deliver the program and that the physiotherapist now had no idea of what the nurses were doing:

> She [the former head nurse] became interested in delivering the program and she wanted her nurses to deliver parts of the program. She felt they could. We agreed that they could develop parts of the program, but specifically leave us the parts of the program which required us to deliver our information. The nurses have developed their portions of the program. They designed modules. I cannot give you an opinion of the changes that I've seen because we've not even been in to audit any of their delivery of the programs. We haven't heard how they deliver them. I haven't seen any of the modules yet. All I know is that they're planning to write the modules. I don't even know if they're completed yet. I haven't seen the module and I have no idea what they are doing. I have no idea where their portion of the program stands (Interview 42, Excerpt:2).

The physiotherapists had been delivering parts of the old program, which did not require their specific expertise. In addition, they did not have enough time to teach the program and to give therapy to individual patients. Therefore, they did not mind when nursing decided to teach parts of the program. They had conducted an in-service session for the nurses and the physiotherapist had the impression that the nurses respected the physiotherapists and that the nurses were somewhat uncertain about their ability to teach the program:

> There were portions of the program that we didn't resent giving up because they were portions of the program that nurses, we thought, could deliver with no difficulty, that we had been delivering and didn't require our specific expertise to do so. That wasn't particularly the issue. We were even asked to go up and give the nurses in-service on how we delivered the portions of the program. We felt that we had gained their respect for our ability and for our knowledge. We did this. Apparently the nurses voiced quite clearly, "Oh boy, why do we have to do this? This is too difficult for us to do. We don't want to have anything to do with this." The nurses were in actual fact saying, "Although the head nurse may want this, we don't want this. We're too frightened to deliver this, it's too much work. You people have been doing it for so long, why don't you go on doing it?" That is what we sensed initially. However, they continued on with the program. I think it was little things that happened after that in conjunction with their program, in conjunction with the physicians, that we weren't kept aware of that caused the problems (Interview 42, Excerpt:3).

According to the physiotherapist, problems with the nurses began to occur after the former head nurse resigned from the unit. The first problem was that the nurses decided to revamp the program and had not kept the physiotherapy department informed of the changes:

> When we united with the nurses, we didn't have a problem delivering the program with [the former head nurse]. I don't know how much she did in redesigning the program. It wasn't until she left and the other nurses stepped in that they decided to overhaul the whole thing, revamp it and get it done into modular form. We felt that we weren't kept in contact enough (Interview 42, Excerpt:4).

The physiotherapist thought that the nurses had designed a manual containing two components, a nursing component and a physiotherapy component. However, the physiotherapist had not been asked to develop the physiotherapy component, but instead had been asked to correct what the nurses had written about the physiotherapy component. She now thought that two manuals had been produced which were not consistent. However, the nurses had not contacted her about reviewing the two manuals for consistency:

> Something that had been designed here had all of a sudden been split into two sections. They had made up a manual with a definition of a physiotherapy component. We felt that we were at the side looking in. There was very little communication between the two groups. As it stands there's a tendency for us to have two different copies of manuals, although they did ask me to correct their interpretation of the physiotherapy component (they had actually written it for me to correct). I felt that perhaps if they had asked me and there had been a little more communication, I would have written one that was in our manual because I wanted the manuals to jibe. I feel pretty sure the manuals do not actually jibe at the moment. The last time I spoke to nursing it was a matter of, "When the modules are completed, that's when we'll take a look at them." I don't know if they're completed, they haven't made any contact. I haven't seen the nurse who's doing it for quite a while. I'm assuming that she will actually make the contact with me when they're done so that we can look at their modular form (Interview 42, Excerpt:5).

A second problem area focused on criteria for selection of patients to the program. The physiotherapist confirmed the earlier reports of the nurses that problems had occurred over who established the criteria to be used to select patients for the program. The physiotherapist gave her version of the "tiff". These problems, according to the physiotherapist did not exist when the former head nurse had been on unit Y:

> There had been no argument on the criteria. The initial nurse who was the head of the unit agreed with the criteria and allowed us to go ahead and define the criteria and select the patients who fit the criteria. Only after one or two sessions did I discover that other individuals were walking into the session room whom I did not know, didn't even know their diagnosis. I said to them that unless I had personally conducted a sort of interview with them and decided on their appropriate diagnosis, their willingness to participate in

the whole of the program and not just portions of it, that I was afraid I wouldn't be able to allow them into the particular session. Besides, it was a continuity sort of a deal where if you miss one, you'd not follow the other one. I asked them if they would mind if they didn't attend. I heard later on, according to the nurses, that I had kicked them out of the room. I thought there was some insensitivity as to the description of how I asked these people out of the room. I was perturbed that this was coming across, that I had kicked patients out of the room. One of the nurses came and asked me what was my criteria for having patients sent to the program. The criteria was in the manual. She voiced an opinion that she felt they were too strict and she felt that we needed to work on this a little more. So we did. We had a meeting with the nurses. We sat down and read out the criteria. By the time we had read out all the criteria there really was nothing wrong with any of them. They agreed that they were perfectly O.K. But that wasn't before I had heard through the grapevine once again how stupid my criteria were. One of the criteria had said that you have to be able to speak English. In actual fact, if they had understood and listened to what I said, it was to be able to *understand* English. I felt that we'd been delivering it and they had recognized that we'd been delivering it. There was a certain amount of, I believe, animosity toward the program. They had different ideals. They believed that anyone that wanted to go into the program should be allowed to go in, anytime, any place, any portion of the program whether they could speak English, whether they were hard of hearing. The criteria were no longer important. I felt, no, if I was going to deliver the principles of treatment and the use of heat and cold, I wanted to be sure that I was delivering to people who had [the disease]. As a patient, I sure wouldn't want to sit in on a session just for interest sake or wonder if I had the disease and learn all that. I would have been quite scared. So we laid the criteria down. I thought I was being personally attacked. It had worked for two years. Why all of a sudden, why wasn't it working? It had worked perfectly well but under a different person. I had to recognize that it was a *people* thing. In the meantime, apparently the nurses had pursued their contact with the physicians and the physicians in turn has said to them that they should be organizing the program and they should decide who should go into the program. In other words they, I suppose, should be setting up the criteria for delivering the program. This was something that we had been doing as a result of interviews that we were giving the patient at the time of their initial assessment. We had questions amongst our physical assessment which would have determined whether or not a) the patient was appropriate for the program and b) whether they wanted to be part of the program. Once we had established that they

> wanted to go into the program and participate to the full and were able to learn the program, we gave them the necessary information. We gave them pamphlets, reading literature and sent them back up to the ward. What was happening, when the nurses decided to be a part of this and make some decision as to whether or not patients went in to the program was this: They would ring down and give us four or five or six names of patients who had been admitted for the program. We would see the patients on initial physical assessment. We'd find that on further discussion with them and telling them about the components of the program, and the time involved that some of them changed their minds and said, "I don't wish to go through it." Then we would notify the nurses and say, "So and so doesn't wish to be part of the program." Then I suppose there was a undercurrent, "Well, we decided and now you're telling us so and so doesn't wish to part part of the program." However, we've continued in that vein and they've accepted it. And when patients are referred for the program, we receive the official requisition for entrance to the program from the physician. We won't have a requisition for every patient on the program, but for out-patients that are referred to the program, the requisitions are sent to us. In other words, the nurses are not aware of out-patients going through the program until we notify them that we have three out-patients to go through the program and give them their names and phone numbers. So there is not a very deep understanding of who's delivering what. Are we sharing this? Is one part having a greater responsibility? Who's deciding who's doing what? It's a total mess (Interview 42, Excerpt:6).

The third problem involved timing the patient admissions to coincide with delivery of the program.

> We've had some problems with them [the doctors] admitting people at the right times for the program. They're admitting people at the wrong times of the month to the program. That could also be a problem with nursing. They [the nurses] agreed that they would sort out all the names of the patients that the physicians wanted in the program and admit them at the right time. That's going a little haywire. We have people right now who should be in the program but we're not running one. To run it one-to-one is not cost-effective (Interview 42, Excerpt:7).

The physiotherapist, at first, did not confirm the nurses' reports that conflict had occurred between the former head nurse and the physiotherapist:

> We agreed that nursing could play a role in delivery of the program, we had lots of communication and lots of support between these two areas. We worked so well with [the former head nurse]. For the year and a half that she was here there were no problems with the program, not at all. She had her people delivering it. Although I do believe that when she left, they uncovered that there was probably very little established, on her part, of a new program. There was very little information left lying around for them (Interview 42, Excerpt:8).

The physiotherapist at first did not confirm the nurses' report that conflict had existed between the doctors and the department:

> We had no problem with them [the doctors] at all. We would see patients and decide who was appropriate for the program. We would inform the weekly ward rounds that they [the patients] were on program. They [the doctors] were only too happy. One of the physicians on ward rounds would even talk about the program to new residents and interns. He would commend it in public saying that this was an important part of patients' stay in hospital and of the management of the disease - to receive an educational program so they could then take care of the disease themselves at home. He was very willing to pluck the program in front of the residents and interns. He was very supportive (Interview 42, Excerpt:9).

However, as the physiotherapist discussed the role of the physiotherapy department in the ward rounds, which were conducted on the unit weekly, one began to sense that conflict had existed between the physiotherapy department and the doctors, and the physiotherapy department and the head nurse. Before unit Y moved to the new location, the physiotherapists were involved in wards rounds on the unit. Each doctor would tour the unit on a rotational basis with the physiotherapist and occupational therapist and visit the respective patients. In addition, the physiotherapists would attend the after-ward rounds conference where all the doctors, residents and interns discussed the patients. At this time, the physiotherapists would present a report on each patient.

Two problems had arisen. First, when unit Y moved to the new location, the former head nurse had discouraged the physiotherapist from attending the ward rounds because the former head nurse felt that this resulted in too many people in the patient's room. However, since the former head nurse left, the physiotherapists were again attending ward rounds. Second, the doctors had not displayed an interest in the reports which the physiotherapists gave at the after-ward rounds conference. The former head nurse had discussed this observed lack of interest with one of the doctors and wondered if the doctors would rather have the practice discontinued. According to the physiotherapists, the doctor had said, "Fine." As a result, the physiotherapists' involvement in after-rounds conference was dissolved.

The physiotherapist speculated about the causes of the problems with the nurses and the doctors. First, she attributed the problems to a lack of communication between between the two departments and to competition between the two professions.

> Physiotherapist: That's a problem, the lack of communication.
> I: Have you been able to figure out why there's a lack of communiciation?
> Physiotherapist: I seriously, sincerely think that there might be some competition here. The program was designed down here. It ran two or three years before nursing became involved. Nursing only became involved because a new head nurse joined the unit who saw the nurses were professionals

> and could be involved in a teaching program, could be taught to teach a program of this nature and decided that they could play a role in the delivery of the program (Interview 42, Excerpt:10).

Second, the physiotherapist thought that program development and implementation had been done all wrong. The doctors did not back the program and no one was co-ordinating the activities. The interview was stimulating her to analyze the problem:

> I think what has happened is that we have done it all wrong. We haven't included the right people in the first place. We don't have the backing, and the strange thing is that we still don't have it. It's a shame that nobody up until right now (I'm sitting here saying this as a result of your questions), that this has not occurred to me before. We're strangling ourselves very slowly and wondering what the other side is doing when in actual fact we could be going about it in the right way. Going to someone and saying, "Look, we are having problems in communication, we need to sit down and discipline ourselves to communicate and we need a person at the head who can bring us all together. Let's get one manual, one philosophy and one group of people in accordance. If no one can be in accordance then goodbye and forget about it (Interview 42, Excerpt:11).

She explained that the "backing" had to come from the doctors:

> I: Where is this backing going to come from?
> Physiotherapist: It has to come from the physicians for them to comply. I believe that we don't have 100 percent compliance by the physicians because they are not a part of it and do not have control and have not had control in what has gone into the program. Even if they saw portions of the program now or listened to the way that some of the information was delivered they may say, "No, we don't want this delivered or delivered in this way." I feel that we have to have the backing and support of the physicians first of all because after all it's through them that we receive our patients in the program (Interview 42, Excerpt:12).

According to the physiotherapist the cause of the problems was that control of the program had been taken over by the nurses:

> The problem that arose was the personal feeling, amongst all of us, that another area had stepped in. We resented their coming in on something that had taken us a year and a half to sort out, set up, and to deliver. We were extremely proud of the high quality of the care, although we had, of course, no means of evaluating that at the time. It was a matter of "We're going to take and we're going to take it forcibly and once we've taken we're not going to tell you what we're doing." Then, it was a matter of "We're going to communicate with the physicians and get their support and you're going to go to the bottom of the pole." That's exactly where were felt we were sitting and that's exactly where we feel we do sit. We designed it and we're now the forgotten unmentionable heroes. I think that's very strongly how we feel. The nurses have taken the total control. We have very little. What we do have, I think is maybe annoying them. That's the decision of who finally goes through the program. We give out the pamphlets, we give out the reading literature and we give it to only those people going into the program. We're just wondering when the day comes when they'll say, "We're going to take this, too, so that we can give it out up here." At that stage of the game, I think we'll probably all break down and cry and say, "We have lost total control. We've let them take without establishing that there's no upper hand in this. There's just hands across the table. We're all doing one job. It's the same job and it's an equal job (Interview 42, Excerpt:13).

Fourth, in addition to the lack of communication, the physiotherapist also thought there had been misinterpretation of certain events, which had occurred during delivery of the program, on the part of some of the nurses:

> It was the other little things that were happening, that we heard through the grapevine, through O.T. The O.T. knew someone who was very much part of the program. O.T. would hear things and come and tell me. We'd be aghast at some of the things that were going on that we weren't made aware of. The innuendoes that were coming as a result of the sessions that I was delivering. The way information conveyed that I "kicked" people out or I said they had to speak English. It was the tone of the voice that went with that. It was very hostile from their point of view. I thought, "Something is

> going on here. I have said something which has been taken and has been converted into something with a little bit of anger behind it. What have I done, what have I said, to make the nurses separate from me?" (Interview 42, Excerpt:14).

Fifth, the physiotherapist was receiving no feedback about development and delivery from the program co-ordinator:

> We decided to add a session to the program. I sent a memo to the head of the program. I notified her of what we were going to do, but I've never had one memo from nursing letting me know what's happening or what stage they're at. I really don't know where they are. We sat and scratched our heads down here and said, "What is it that we've done? Should we confront?" One of the girls said, "No, let's not confront. Let's see if it works its way out." It had to be a people thing because we worked so well with the former head nurse (Interview 42, Excerpt:15).

The physiotherapist suggested ways in which the program should have been planned, developed, and delivered. First, a committee should have been formed:

> I would have liked to have seen a committee at the head of it all whereby we kept in touch as to what we had accomplished in our portions of the program, what was in the program, what information they were using in the program so there wasn't duplication among the different groups whereby we reported frequently to find out at what stage of development we were (Interview 42, Excerpt:16).

The committee members would include a doctor, the head physiotherapist for unit Y, the head occupational therapist for unit Y, a nurse, a teaching manual design expert, and a secretary:

> The committee would have a physician. We would have required a head of each area, a head of physiotherapy [for unit Y], a head of O.T. [for unit Y] and of course a nurse who was, I'm not too sure, what specific role she should have in it, whether she should be a staff nurse or a head nurse or

> someone in the teaching area of the nursing profession. I have no idea, I would have expected that they would select who they think would be appropriate. I also think that we should have someone on the committee who is proficient in designing a manual. Someone who was able to ask of everybody the information he wanted to go in the manual and dictate to them what was needed to complete a manual whereby if I came on and knew nothing about it I could go off and deliver a lecture in half an hour. I think we need the expertise within a committee to tell us what is required to make a good teaching manual. And of course someone to take down minutes (Interview 42, Excerpt:17).

The physiotherapist reiterated that the physicians needed to be involved and interested, and that the program needed the approval and input of the physicians:

> We should have had a physician involved because the physicians are the last people who do really comprehend what is going on and what is in the program. We need their support, we need their interest and I mean all of them. To get all of their interest is going to be a great problem. I think we have passive interest among the three of them and maybe enough interest in the fourth. I suppose as long as we have one active interest it could work, but it would sure be nice to have the four. We should have their approval. We need their absolute total approval and we need that input (Interview 42, Excerpt:18).

In June, the former head nurse consented to be interviewed. A semi-structured questionnaire, grounded in the data which had emerged during the period from December, 1982, to June 1984, was used to guide the interview. The former head nurse was asked to respond to nine questions. Question one was: What did you consider your role as head nurse to be during the development of the program? The former head nurses responded that she had: ". . . taken care of the details" (Interview 3, Excerpt:1), particularly in the areas of: ". . . providing direction to the teaching nurses and co-ordination"

(Interview 43, Excerpt:2). She had provided direction about the teaching and planning process and had provided the direction to initiate the program. It was she who had contacted the Association, had designed the timetable, had prepared the initial draft of the proposal and had identified the funding needs of the program. Co-ordination of the program involved rotating the staff through the program, identifying staff who were willing to become involved in the program, providing time for the staff to develop the program, and facilitating the specific activities of content development, writing objectives, doing revisions, and developing the evaluation component of the program.

Question two was: What did you consider your role to be with the doctors during the mounting of the program? The former head nurse thought that her role had involved: ". . . informing the doctors about what was going on with the program and involving them in a team decision to establish the criteria for the selection of patients to the program (Interview 43, Excerpt:3)." In retrospect, she wondered if the doctors should have been involved in checking the developed content. She commented about the reaction of the doctors to the nurses "taking on" the program and thought that ". . . Dr [Z] was a prime mover in getting the program changed (Interview 43, Excerpt:4)." He was supportive and the other three doctors went along with his ideas. She also commented that: ". . . there was a problem with physio on the old unit. The doctors were upset because the patients were not receiving their therapy (Interview 43, Excerpt:5)." When the unit moved to the new location, according to the former head nurse, the physiotherapists did not have time to teach the program and do the treatments. Therefore, the former head nurse developed a proposal, for nursing to teach part of the program, and discussed it with Dr. [Z] and the physiotherapist. The proposal was funded and: ". . . nursing took over (Interview 43, Excerpt:6)."

Question three was: What would you identify as the factors which contributed to the success of the program? According to the former head nurse, there were many factors. First, she as head nurse had desired the change. Second, the change was self-initiated rather than imposed. Third, the staff supported the change, both for themselves and for the patients and their families. Fourth, the doctor-nurse relationships on the unit were comfortable. Fifth, the nurses saw the program as: ". . . a special thing for the unit. Even the nurses who were not involved thought it was good. The nurses were upset when the program was delayed (Interview 43, Excerpt:7)." Finally, the nurses were willing to start doing it on their own time or on regular time.

Question four was: What would you identify as the factors which inhibited the success of the program? First, according to the former head nurse, the program had been:

> . . . held in abeyance because the [chief executive nursing officer] had wanted to get involved. She [the CENO] had wanted the [chief executive officer] of the hospital to be aware of the program. We had to wait until he returned from being away (Interview 43, Excerpt:8).

When [the chief executive nursing officer] became involved:

> . . . that led to a slowdown and led to difficulties with funding. The finance department then became involved in the

> discussions. So by [the chief executive nursing officer] stepping in, that moved communication out of my hands, where I could monitor the situation, to being between the finance department and the Association (Interview 43, Excerpt:9).

Second, the former head nurse talked about the problems with the rehabilitation department, specifically the physiotherapist. According to the former head nurse:

> . . . the rehabilitation department had problems with the doctors. There were role problems. The doctors did not perceive physio and O.T. to be as effective as O.T. and physio would have liked to have been perceived. The effects spilled over to result in problems between physio and the nurses (Interview 43, Excerpt:10).

According to the former head nurse, she and the physiotherapist "got along well." The former head nurse could: ". . . control and guide the physiotherapist to reach a compromise (Interview 43, Excerpt:11)." She thought she had been able to: ". . . counteract any control or intimidation by the physiotherapist (Interview 43, Excerpt:12)." The former head nurse was aware that physio had a "lot of ownership" in the program and that change was a "loss to physio." She had considered this fact and had been sensitive to the needs of the physiotherapy department. However, according to the former head nurse: ". . . some of the nurses became gung ho about the program and would run off at the mouth to the rehabilitation people. This got their backs up. The nurses exacerbated the situation (Interview 43, Excerpt:13)." The former head nurse had to: ". . . teach the nurses to be tactful and sensitive to physio without dampening their enthusiasm (Interview 43, Excerpt:14)."

The third inhibiting factor was that all of the staff were not motivated to become involved in the program:

> I wish I could have motivated the whole staff. Some nurses were afraid; they hadn't taught before. Some were not committed to spending the extra time. Some were new to the unit and were apprehensive. Some had never done anything like this before (Interview 43, Excerpt:15).

Question five was: What would you consider to be successful outcomes of the program? The former head nurse reported that she would like to see more staff nurses involved in the program, that revisions would occur on a continual basis, that out-patients would be able to attend the program, that Association members would become more involved and perhaps teach parts of the program, that eventually the program may become a city-wide endeavour, that good audio-visual aids would be developed, and that the families would become involved in the program.

Question six was: What would you change if you were starting such a program again? Two areas which should be changed were identified by the former head nurse. First, the planning should be done differently:

> It was too fast-track. I would make sure that everything was structured. The AV stuff should be developed along with the objectives. Good evaluation tools should be developed which look at the program itself as well as the outcomes of the program. Maybe the content should have been developed, but that is developmental, it changes as you go along (Interview 43, Excerpt:16).

Second, she would provide more staff development and would have preferred to have more staff to implement the program:

> I would develop a situation to teach the nurses how to teach and give them opportunities to practice group presenting. I would like to have more staff (Interview 43, Excerpt:17).

She explained how these changes would be implemented:

> I would use a pool of part-time nurses to plug the positions and take the teaching nurses off the floor, get them away from the bedside (like we did when we moved to the new location), for some development and planning time. Then I could teach the nurses. However, the economic crunch hit to mess up the plans. The nurses became job survival oriented and patient-centered. I'd also encourage them to do self-learning, some reading, and writing some objectives (Interview 43, Excerpt:18).

Question seven was: What components are required to mount a successful program? First, according to the former head nurse, committed administrative support was necessary. She would suggest that the proposal be set through the formal channels external to the nursing department, for example to the chief executive officer and the Board of the hospital. Second, she wondered what the role of a leader should be in the change:

> Should the head nurse let the staff initiate the change, or do you sow the seed for change and let them roll with it or do you sow the seed and start the ball rolling and pick up on staff motivation and involvement along the way (Interview 43, Excerpt:19)?

Third, as reported by the former head nurse, the leader would require: ". . . lots of energy and she needs to be sensitive to role-modelling (Interview 43, Excerpt:20)." She wondered if a head nurse who worked very hard made the staff feel guilty and in fact increased the distance between a supervisor and her staff or if this kind of behavior increased productivity as the staff tried to take on the behaviors of the model. Fourth, staff should be carefully selected. Fifth, the philosophy and expectations of the head nurse should be made clear to prospective staff during the employment interview. The candidates should:

> . . . be made aware of what they are buying in to. The staff needs to buy in to the change in a conscious way. The leader needs to continuously reinforce the change behavior that you want. It's difficult to shed old experiences and they want to fall back on previous ways of functioning (Interview 43, Excerpt:21).

Question eight was: What problems had to be overcome during planning, development and implementation of the program with a) the patients, b) the Association, c) other departments, d) the doctors, e) nursing administration, and f) the staff nurses? The former head nurse reported that she could not predict which patients were going to be admitted and which patients would be suitable candidates for the problem. She did not think that any problems had occurred with the Association: ". . . they were good in terms of funding it (Interview 43, Excerpt:22)." The problems with the rehabilitation departments were discussed in answer to question four and she thought that the response from both the social services department and the pharmacy department had been good during implementation of the program. No problems had occurred with the doctors. The former head nurse had previously discussed the problem of interference by the chief executive nursing officer. She wondered if part of the reason for the interference was because of the kind of relationship which existed between the chief executive nursing officer and the director. The former head nurse thought that the director of nursing services had been very supportive. The head nurse had reported mainly to the director and did not know what problems the area supervisor may have had or may have caused. The former head nurse thought that some of the staff had been carefully selected and had met her expectations while the ones that she had selected when she was rushed had not met her expectations and had not "bought into" the change.

The ninth and final question was: What side effects, events, behaviors occurred during development of the program that you did not expect? The former head nurse identified two problem areas which she had not expected. First, she had not expected a recession to occur which in turn affected the budget of the hospital and implementaton of the program on unit Y. Second, she was somewhat surprised that the staff nurses became so "uptight" about implementing the program.

The final interview in June was conducted with Ann, the program co-ordinator. She reported on implementation of the sixth scheduled program which was being delivered at the time of the interview. All three nursing classes were being taught during the evening. However, the pharmacy, the social services, and the physiotherapy lectures were being given during the day. Ann was concerned that the patients did not have time to rest: ". . . I would like to ask the patients to keep a diary of their timetables to see how much time they really have off (Interview 44, Excerpt:1). Family members were attending this sixth program. Two staff nurses had joined the teaching team and had attended the teaching classes as observers. One of the teaching nurses was going to teach the quackery class in the sixth program. However, the newly developed quackery module was still at the typist and Ann hoped it would arrive on the unit in time for the new teaching nurse ". . . to have a couple of hours to look it over (Interview 44, Excerpt:2)." Ann and Marg were going to attend a staff development workshop on patient teaching the next day. The director had brought in an expert from another province to conduct the workshop. According to Ann: ". . . the director was going to try to get the lady up here to our unit, but I guess she was too busy (Interview 44, Excerpt:3)."

Ann reported that in addition to problems with scheduling the classes and with the typing, numerous other problems were occurring during implementation. First, the medication module was still not completed. Second, no follow-up had been done on the patients. Third, there was no time or the money to continue program development activities and to produce a manual of the standard she had expected:

> . . . it's just mediocre work that we've done. We only have two extra hours a month which are funded by the Association and those have been used up to pay the two new teaching nurses to come and sit in on a lecture (Interview 44, Excerpt:4).

Fourth, the problems with the physiotherapy department continued to exist. According to Ann, the physiotherapy department was not talking to the occupational therapy department or the nurses:

> It's bad right now because we don't even know what time the patients are supposed to go down to physio. Physio said to us this morning, "It's none of your business, we look after the porter system. We know when the patients are supposed to come down and don't worry about it." But you see O.T. had set up a lecture this morning. While the patients were at

> this O.T. lecture, physio was on the phone saying, "Where's Mr. So and So? They're supposed to be down here for physio. There's real problems. They're not talking to each other and they're not talking to us (Interview 44, Excerpt:5).

Ann did not think that the problems with the physiotherapy department, in particular with the physiotherapist who was responsible for unit Y, could be resolved at the unit level:

> I don't think that we're going to resolve it at the unit level. I think it's going to be at the [director's] level and the supervisor of physio that are going to have to give the directions. [This physiotherapist] is not going to listen to anybody else out of her department. She's the main problem. She's very strong and she wants to decide everything (Interview 44, Excerpt:6).

In addition, according to Ann, the doctors had problems with the physiotherapist and had given up:

> She [the physiotherapist] has really run her own show. The doctors just throw up their hands. They don't even try to do anything about it. They just ignore her most of the time, instead of resolving the problem. For example, this is the only place I've ever seen that the doctors don't order the physio specifically. They just say "physio consult." Well, my gosh, that leaves it wide open for physio! They decide what's best for the patient? I've never heard of that before. Most of the time the doctors are very specific about what they want done, but not on this floor (Interview 44, Excerpt:7).

Ann thought that a power struggle existed between the physiotherapists and the doctors over the domain of each discipline and she began to wonder about the domain of nursing:

> There's a power struggle. I think some of the physiotherapists really think they know more than the doctors. I doubt that they do. Could you see nursing doing the same thing? I mean nursing is a discipline. Would you like to

> see the doctors ordering "nursing care" for these patients and we'd have wide open scope? We could start I.V.'s and do any assessment we wanted to and any mobilization we decided to do, regardless of inflamation or infections (Interview 44, Excerpt:8).

With probing, Ann tried to expand on what would be included in the domain of nursing?

> I: If nursing was to do that, what would nursing say was their area of expertise, that the doctors wouldn't know enough about and would have to be told about by the nurses?
> Ann: I would say that nurses know more about dressings and how to treat different wounds, like ulcers. These patients get a lot of ulcers and we suggest things to the doctors. We say, "We think we'd like to try such and such on this patient." We suggest things like, if a patient is running a temperature and is not drinking and has a very poor output, we'll suggest I.V.'s. We watch those things on our own. But we certainly wouldn't start ordering I.V.'s. I guess maybe nurses know our parameters better. I don't know. I think that it's a team. It should be a team effort.
> I: And I hear you saying that the doctor is the head of the team and the co-ordinator and has the final say?
> Ann: Yes, I think so. I would like to see the doctors be a little more specific with physio orders (Interview 44, Excerpt:9).

The fifth problem, as reported by Ann, was that she was not receiving support from nursing administration, in particular the newly appointed head nurse or the area supervisor, to work on program development activities or to implement what had developed:

> [The area supervisor] and [the new head nurse] know what should be done because I've talked to them about it. They have told me that there is no money. They have told me not to work on the teaching program while I'm on duty with the patients, so what else can I do? I have been reprimanded for as much as walking to the copy room and copying sheets, and being away from the ward for five minutes. They don't want me even doing that. I mean we're running out of assessment sheets and I would sneak off at coffee break and do some of this work. I get bad vibes from it. I haven't had any

> run-ins with the new acting head nurse at all and maybe I should ask her about doing some of this work or if she wants to appoint somebody else. They seem to think that I'm always looking for extra money or extra hours (Interview 44, Excerpt:10).

Ann talked about the reasons for this lack of support. One reason was that the new head nurse and the area supervisor really did not understand how complex development activities were: ". . . they don't realize how much time it takes to work on a program like this. They have no idea (Interview 44, Excerpt:11)." She wanted to go to the director, who would understand, but she had to use the proper levels of communication: "If I could talk to the director, I think she would understand, I think she realizes. But I can't go to her, I have to go through the other levels (Interview 44, Excerpt:12)." Another reason was that Ann and the area supervisor did not get along:

> I: Can you go to the area supervisor?
> Ann: No. The area supervisor and I have had bad times, so I'm just biding my time right now. Maybe I'll write out a list of things that should be done, and if I have time, write some kind of a paper (Interview 44, Excerpt:13).

A third reason for lack of administrative support, according to Ann was that the area supervisor had not read the material:

> I don't know if she's been doing teaching programs. She gave me the impression that she was really disappointed in the manual. I said, "What specifically is wrong with the manual? She said, "I think there should have been a lot more information in it." I said, "In three weeks you can't write that much material." Most teaching programs take years to develop. I said, "I'm not happy with the modules either, I know that they are far from perfect, but at least there's something there." I said, "Well, what's wrong?" "Well," she said, "I really hadn't read it that carefully." So she couldn't really say what she was talking about. I know that

> the bureacracy takes a long time to wade through and I'm not going to get all upset. It'll take time (Interview 44, Excerpt:14).

Ann confirmed that she was feeling very frustrated, but that she did not think the rest of the teaching nurses were frustrated: "I think it's only me (Interview 44, Excerpt:15)." The final reason for lack of administrative support was that Ann did not get along with the new head nurse. Ann had also applied for the head nurse position and was not chosen. According to Ann, the new head nurse had now taken over contact with the Association. Ann felt that she was no longer co-ordinator of the program and felt that the new head nurse would like her to say so:

> I applied for the head nurse position. I knew I needed more power to get things done. I was frustrated. I knew that the director was going to be on the selections committee and maybe she would see that it would be nice to have somebody interested in the program, as a head nurse. But they thought different and I'm over that. I realize that they were looking at something different for the head nurse position. I haven't been talking to the Association lately. That's another thing, the new head nurse didn't seem to want me to phone them anymore. She wanted to have the meetings with the Association. I hesitate now to phone. When we first started working together she was the acting head nurse. She wanted no part of the teaching program. She said, "Ann, just take care of the teaching program and let me know what hours to put on their payroll." So I didn't come to her with every little detail. I tried to keep her in touch with most of the things. Then all of a sudden she started wanting to be more involved with the teaching program and involved with all the decisions and wanted to know everything that was going on. I feel that I'm not a co-ordinator of the program anymore, that it's been taken away from me. I guess that's alright. There's nothing more to be done because there's no money anyway. I think she decided that she was going to be in charge of everything. I stopped communicating with her. I didn't want to communicate very often with her. We did seem to clash. I think she probably would like me to say, "Look, I don't want to be co-ordinator of the teaching program

> anymore." I probably will say that in the next while (Interview 44, Excerpt:16).

The sixth problem was that Ann did not think a staff nurse could be a leader because staff nurses did not have any power. She knew she had not been a strong leader, but she did not think that a staff nurse could be a leader anyway:

> I'm not a very strong leader. I don't demand a lot of things. I guess I demand them too quietly. I just state what needs to be done and for some people that's not loud enough. However, I think that it doesn't matter how loud you are. As staff nurse, I don't know if you're going to accomplish a lot. You're always going to be stepping out of bounds. If you go straight to the physio department somebody's going to say, "Well, that's the head nurse's job to talk to the other departments (Interview 44, Excerpt:17).

Finally at the end of the interview, Ann made some suggestions for changes to the program. She thought that the head nurse of a unit with a teaching program should have experience with teaching programs: ". . . then you know what has to be done and you don't criticize your staff for spending a lot of time on it (Interview 44, Excerpt:18)." She did not think that either the former head nurse, the new head nurse or the second acting head nurse had experience with patient teaching programs. Topics should be added such as pain control and methods of relaxation. A dietician and a psychologist should be added to the team. She confirmed, without probing, three suggestions of the physiotherapist. One manual which contained the contributions for all the disciplines should be developed; team meetings with all the team members should be held once a month; and the doctor should attend the meetings.

## September, 1984: The Final Interviews

Ruth reported that a program had not been delivered in July and Ann reported that the program had not been conducted in August. Ruth, Marg, Ann, the new teaching nurse, and the second acting head nurse were interviewed within a eight day period in mid-September. These were the final interviews in the study.

Ruth was to teach the stress lecture during the September program but forgot which night she was scheduled to give it. Therefore Marg gave the lecture. According to Ruth, both she and Marg did not like giving the stress lecture. However, she reported: ". . . nothing has been done about that lecture, not a thing. The biggest problem is that the motivation is gone. Ann and I want to leave the program. It's dying a very quick death at the moment (Interview 53, Excerpt:1)." Ruth talked about what had happened to the motivation. A meeting had been held in June among the second acting head nurse, the new head nurse (who came in from her leave of absence), the three original teaching nurses and the two new teaching nurses. The new head nurse had told the teaching nurses that it was their responsibility to notify the patients before each class and to write a reminder on the board and that the ward clerk and the charge nurse were going to have nothing to do with the program. Ruth thought: ". . . what am I working on this for? They just want the program to be printed up so they can meet their own objectives (Interview 53, Excerpt:2)." Ruth talked about a lack of enthusiasm:

> There's been no enthusiasm from the head nurse, it's never discussed, there's been no pats on the back, no extra time

> given for us to do some work on the program. I don't care how enthusiastic we are, if we don't get any response, from someone other than ourselves and the patients, the program won't last, it is going to fold (Interview 53, Excerpt:3).

According to Ruth, the program should be stressed as an important part of the patient's lifestyle, word should be spread about the program throughout the hospital, the new head nurse should take responsibility for spreading the word, the nurses should be allowed to go to the other units in hospital X to describe the program, the director of nursing service and the area supervisor should solicit feedback from and give feedback to the nurses about the program, each nurse should be given time for program development on a continuous basis, the teaching nurses needed to sit down as a group and work out the problem areas, and the problems with the doctors and the physiotherapy department had to be addressed. However, on the whole, Ruth thought it was too late to salvage the program, and: ". . . if a miracle doesn't happen by November, then I'm leaving (Interview 53, Excerpt:4)."

Marg had given the introductory lecture and the stress lecture in the September program. She reported that: ". . . the wrinkles seem to be out and it's running not badly. I feel good about the program now. I feel like I can carry my weight (Interview 55, Excerpt:1)."

According to Marg, the second acting head nurse and one of the new teaching nurses had taken over leadership of the program until the new head nurse returned from her leave of absence. The new head nurse would then assume the leadership. Ann was through as leader. Marg thought that the leader should come from within the group. However, it would be difficult for a staff nurse to be leader because staff nurses did not go on Monday morning rounds with the physiotherapists and the staff nurses rotated through the different shifts.

Marg thought it would be nice if the nurses knew about the whole program (physiotherapy and occupational therapy). The teaching nurses should nurse the program patients and should go on rounds with the head nurse, the residents and the physiotherapists. Patient care should eventually have a holistic focus.

At the present time, Marg thought these ideas were still idealistic. She was optimistic that over time, when all the nurses on the unit became involved at their own pace and when the new head nurse returned to the unit, some of these suggestions might be implemented. Marg commented about what outcomes had resulted due to her involvement in the program and in the study:

> It's made me realize that the program is an important part of unit Y. I'm getting out of it what I came into it for, an interest in teaching. It's something different, it's challenging. And our recognition comes from the patients. It always has and it always will (Interview 55, Excerpt:2).

The new teaching nurse had taught the quackery lecture three times between June and September. Prior to teaching, she had observed the other teaching nurses as they taught the introductory and the stress lecture. She described her reactions to teaching the program. She liked teaching the program and was surprised at how much the patients learned:

> I like it. It's really surprising how much those patients don't know. I find it rewarding teaching them. Things I

> would have assumed they know, they don't. It's also a good feeling that they are learning something. It's set up well. They learn so much. It's good (Interview 54, Excerpt:1).

She thought that the patients who were involved in the program knew more about their disease and medications and asked more questions than the patients who were not involved in the program. The new teaching nurse thought that she had learned a lot from teaching the program and that she gave different patient care than she had before becoming involved in the teaching program:

> Now when I approach a patient it's a lot different than before I started teaching. I used to go in and say, "How are you? What treatment did you have? How do you think your [illness] is coming along." It's amazing. Now I hear what they think or that they never knew why they took a pill. Now I understand a lot more than I did before. I knew about [this disease] but not the specifics like quackery. I didn't know as much as I do now. I can approach a patient differently. Their care is different than it used to be. It would be great if all the nurses knew that, too (Interview 54, Excerpt:2).

She thought that some of the staff nurses were interested in joining the teaching team:

> There's a couple of new girls who have started and are really interested in it. There are a couple of other girls that are just dying to join but they want to know more about it before they join. They have expressed an interest in seeing a couple of lectures (Interview 54, Excerpt:3).

The new teaching nurse mentioned that the program was becoming well known, that she had not know it was so popular until she joined the teaching team, and that this recognition was a form of reward:

> You hear it talked about. I hear that our program is the

> only one, I think, in Canada. I think it's great to see that our hospital has such a well developed program where the patients learn. It's heard of all over the province. A lot of patients hear about it and come in for that reason. The doctors talk about it in other parts of the country and in Europe. I didn't know it was that popular until I joined the program. A lot of nurses have phoned up and said, "I hear you have a teaching program. I have a patient here who's interested in going to see it." That shocked me. That's quite a reward. It makes me proud that I am part of it. It's a good feeling (Interview 54, Excerpt:4).

She discussed some of the problem areas. First, the physiotherapy department and the teaching nurses had some communication problems as did the doctors and the teaching nurses:

> I don't think there's good communication between physio and nurses. I think it would be great if physio came up and said, "This is what we plan to do with this patient, these are the exercises we're doing and maybe you guys can continue it up here," rather than the patients coming up and expecting us to know what's going on. I know some physios come up on Monday rounds but the majority of us aren't included. Physio and nursing are totally two different things. Even with the doctors it's totally two different things (Interview 54, Excerpt:5).

She thought that these problems would be solved when the new head nurse returned from her leave of absence.

Second, the teaching nurses had experienced difficulty in organizing the delivery of the program: ". . . at one point it was kind of confusing. It was a big 'hassle' and the patients didn't know what was going on half the time. The [second] acting head nurse and the ward clerk were having to do all the organizing (Interview 54, Excerpt:6)." The new teaching nurse explained that the teaching nurses were not signing up to teach the lectures, the patients were not being told when the lectures would be delivered, and the out-patients were not called in for the lectures. As a result, a number of patients had missed the programs. The new head nurse came back from her leave of absence and held a special meeting to discuss and solve the problems. The teaching nurses were told that they were responsible for organizing and delivering the program, that the second acting head nurse and the ward clerk would no longer organize delivery of the lectures and call in the patients, and that this new teaching nurse was appointed to be assistant program co-ordinator with Ann. The new teaching nurse thought that the meeting had been necessary, that the nurses were now more organized and that everyone had been assigned a responsibility. The new teaching nurse reported that prior to the meeting she had become frustrated with the lack of organization. She would receive a phone call on short notice to teach a class and: ". . . it was maddening, it would ruin your evening plans (Interview 54, Excerpt:7)." According to the new teaching nurse, Ann, as co-ordinator should have been organizing delivery of the program.

The third problem was that the teaching nurses were not following through on their responsiblity to inform the staff nurses about the program:

> A certain person in the teaching program was supposed to organize a meeting to teach the staff nurses about the program. This hasn't been done. The staff nurses are asking when it's going to be (Interview 54, Excerpt:8).

Ann did not teach in the September program. She had talked to Marg who did teach and reported that this particular group of patients: ". . . didn't contribute and didn't open up to each other (Interview 56, Excerpt:1)." This group of patients was comprised of four in-patients and four out-patients. Ann wondered if the out-patients, who did not know each other or the in-patients, had perhaps had an inhibiting effect on the group. She reported that a large number of patients on the unit at the present time were "off-service" [not the chronically ill] patients. These patients were on the unit because three of the unit doctors were away and were therefore not admitting the regular patients. A program had not been conducted in August because, at that time, some of the physiotherapists and the occupational therapists were on holidays.

Ann reported that the assessment sheets were distributed by the second acting head nurse or the ward clerk to the nurses on the floor. The nurses gave these sheets to the patients and collected them when the patients had filled them out: "If the patients don't fill them out, they don't get filled out. We're not doing anything with the assessments. Maybe we will. I don't know (Interview 56, Excerpt:2)." She reported that a bit more was being written in the kardex on the patients but that no follow-up was done on the out-patients: ". . . we don't keep much of a record on them, we don't write any feedback down (Interview 56, Excerpt:3)." According to Ann, no changes had been made in the program.

> We haven't made any changes. I don't see any money. Maybe there's a need but maybe it's not the time. I would like to see the psychology department used but we don't seem to use psychology much in nursing, not on our unit. I suggested it here but people don't really know what I'm talking about. I should maybe talk to the pyschologist. But I haven't done

> that. I don't know whether I will or not. I'm not in a position of responsibility to do that (Interview 56, Excerpt:4).

Ann had not tried to organize a meeting of the teaching nurses. She had relinquished her duties as program co-ordinator:

> I: At one time you said that you were thinking of getting the nurses together for regular meetings.
> Ann: No, I haven't tried to do that. I told the second head nurse that I felt that the person at the desk should co-ordinate the program. They're the ones who go to physio rounds. It's really impossible for me to call a meeting. I'd come in on my days off. I'd have to expect others to come in on their days off. There's no funding for it. It just doesn't work. I don't have the authority to really call them in and pay them. We had a meeting with the [second] head nurse. We talked a little bit about these things. She seemed to want me to still plan the part where I would get the nurses to say what lecture they were going to take. That is about all the responsibility that I have now, just arranging the nursing lectures. I don't meet with physio or anybody else. I will probably still do some of the record keeping. I haven't said I wouldn't do that (Interview 56, Excerpt:5).

She did not think she was frustrated, disappointed, or disillusioned:

> I: I'm sensing that you are frustrated, disillusioned and disappointed.
> Ann: No, I'm just not trying to do all the things that I had planned. I don't think that anybody wants them. I'm gearing back. We'll carry on the program as it is. I don't think anybody wants any more, including the doctors. I don't think that I'm going to push for anything bigger. I'll carry on. I'll teach when I'm needed. I'd like to get the manual finished. That's all I plan to do, just carry on and get this finished . . . if the [second] head nurse asks for some advice, I might offer some (Interview 56, Excerpt:6).

The final interview during the data collection period was conducted with the second acting head nurse. She was the third person to fill the head nurse position in unit Y between August, 1982 and September, 1984. She discussed her impressions of the program. According to the second acting head nurse, a lot of work and research had gone into the program. She had learned a lot from reading the program materials which had been prepared: ". . . knowing that information and reading everything they have prepared has helped me a lot. It's a lot easier to relate back to the patients (Interview 58, Excerpt:1)." The acquisition of the knowledge had broaden her perspective about her work: "It gives you another avenue to work at. Rather than just doing basic bedside care, you can now be involved with their teaching (Interview 58, Excerpt:2)." Knowing what was taught in the program allowed her to reinforce the patient teaching on the unit: "If you know what's been taught, it's much easier to reinforce (Interview 58, Excerpt:3)." She thought that some of the other staff nurses were interested in learning more about the program:

> I'm finding that we have some very keen girls, even some of the part-time people, who would like a little more information on this. But it hasn't been set up. I can't walk around with a whip and say to the teaching nurses, "Hey, come on guys!" They were supposed to set up in-service sessions (Interview 58, Excerpt:4).

The second acting head nurse discussed the problems which were occurring. First, the teaching nurses were not presenting in-service sessions to the staff nurses as they had been asked to do. The second acting head nurse thought that the sessions had not been planned and presented because the co-ordinator had not been strong enough. According to the second acting head nurse, the co-ordinator's attitude had changed:

> She's become much more laid back. She's got the authority to go ahead and make decisions, to come to me and say what she's going to do and to say, "Let's get going." But there's none of that. It could be that she's not self-directed and it could be just not knowing how to lead. I've got a thousand things to do and I can't keep saying, "Come on guys, where's the material?" I feel I shouldn't have to go after people day after day after day and say, "Look, when are you going to do this?" They know when they're to do it. It's just a matter of setting it up (Interview 58, Excerpt:5).

She thought that the teaching nurses were getting: ". . . fed up. It's just not working out and there has been some dissension (Interview 48, Excerpt:6)." Second, only one teaching module had been developed, typed and proofread. Third, the problems with the physiotherapy department continued: "There's always been a huge gap with communication. They think they're bloody doctors. Not all of the physiotherapists are like that. We've got some real nice gals (Interview 58, Excerpt:7)." Patients were receiving treatments all day: ". . . they should receive therapy in the morning and rest during the afternoon (Interview 58, Excerpt:8)." Fourth, the doctors only visited the patients during rounds, once a week:

> They should each come around and see their patients every morning on a one-to-one basis. We've got one doctor who's a faithful man. He comes around every morning. We've got some patients who say, "I never see my doctor" (Interview 58, Excerpt:9).

Fifth, the area supervisor had nothing to do with the program:

> This is part of her area. If she had helped the girls a little more in the beginning, I think it would have made it much easier. The girls were left to find out on their own

(Interview 58, Excerpt:10).

Sixth, the work environment was unpredictable, making it difficult to deliver the in-service sessions if they had been planned,

> The nurses all work different rotations. We'd have to present each session twice. We'd have to do it in the coffee-room on the unit. We can't leave the unit. There's no one time of the day we can count on the ward not being busy. There are quiet days but you don't know when they are. But we could do it on a quiet day if the information was readily available and the teaching nurse was on the unit (Interview 58, Excerpt:11).

Finally, the second acting head nurse felt that she was caught in the middle: ". . . things are just on hold until the [new] head nurse gets back. I can't make waves. I have to go back and work with these girls. I'm caught in the middle (Interview 58, Excerpt:12)."

She discussed what changes had occurred. A second program co-ordinator had been chosen. There was now a program co-ordinator on each rotation. Two new teaching nurses, one who was appointed second program co-ordinator, had been added to the teaching team and they did not seem to be as frustrated as the original teaching nurses. The staff nurses were interested in the program and although they did not all want to teach, they had supported her when the program activities became overwhelming and offered to help her in any way.

In summary, eight scheduled programs had been taught between January and September, 1984. On September 21, 1984, the investigator left the setting. Again, factors had emerged from the data collected during that period which appeared to have influenced implementation of the planned programs.

## Discussion of Implementation of the Planned Programs

During the nine month period, two sets of factors were evident in the data which appeared to have influenced implementation of the planned programs. The factors are listed in Table 8.2 and are discussed in the next section.

### Factors Which Facilitated Implementation of the Planned Programs

Five factors appear to have facilitated implementation of the planned programs.

Need for the program. Throughout the implementation period the nurses continued to report that the patients thought the program was worthwhile. The new teaching nurse, in particular, reported that patients who were taking part in the program behaved differently than patients who were not.

In addition, the nurses, the second acting head nurse and the new teaching nurse expressed surprise on discovering that the program had become well known elsewhere. The nurses reported that they had received requests from the nurses at other hospitals in the city and in other parts of the province for information about the program, that they had been told the doctors were discussing the program in Canada and other parts of the world, and that patients from other units in the hospital were attending the program. It became evident, as implementation continued, that the program was needed and that the recognition of the need and the knowledge by the nurses that the program was recognized beyond the boundaries of the unit had in fact become factors which directly facilitated the implementation process.

Table 8.2

Factors Which Influenced Implementation of the Planned Programs

1. Factors Which Facilitated Implementation of the Planned Programs
    - 1.1 Need for the program
    - 1.2 External funding
    - 1.3 Leadership
    - 1.4 Support of staff nurses
    - 1.5 Plans for continuation

2. Factors Which Inhibited Implementation of the Planned Program
    - 2.1 Complexity
    - 2.2 Leadership
    - 2.3 Materials production and delivery
    - 2.4 Antecedent conditions
    - 2.5 Multiple realities
    - 2.6 Support of administration
    - 2.7 Adoption process
    - 2.8 Staff development

External funding. Throughout the implementation of the planned programs it became clear that external funding was still required to pay the nurses for teaching the program. Ann reported that although the Association would not pay for planning time, they would continue to pay for teaching time until the year end. Both Ann and the area supervisor mentioned the difficulty in obtaining funds to carry out program related activities. The teaching nurses felt that continuation of program delivery would be threatened if external funding did not continue. Assurance of funding by the Association facilitated implementation of the planned programs.

Leadership. Both the acting head nurse, who was selected to be the permanent head nurse, and the second acting head nurse indicated that they supported the program. The acting head nurse became involved in program related activities with the Association, the hospital finance department, the pharmacy department, and the physiotherapy department. In addition, she encouraged two staff nurses to join the teaching team and she thought that all of the staff nurses should become knowledgeable about the program. To operationalize this objective, she requested that the teaching nurses prepare and present an in-service session about the program to the staff nurses.

A second program coordinator from the second rotation, one of the new teaching nurses, was appointed so that continuity of program delivery would be ensured when nurses from either rotation were on the unit.

The second acting head nurse expressed surprise at how well developed certain parts of the program were, at how effective the program appeared to be and at how much she herself had learned. Although two of the teaching nurses did not particularly like the now permanent head nurse, they all admitted that she did support the program. The support of the leaders on unit Y facilitated implementation.

Support of staff nurses. Although the teaching nurses and the new head nurse reported that some staff nurses were not interested in the program, nonetheless, there was some faint evidence that the staff nurses as a group were beginning to actively support the program. The new head nurse, the second acting head nurse, and the new teaching nurse commented that some of the staff nurses were eager to join the program. Even those who did not want to teach appeared to support delivery of the program and rallied around the second acting head nurse when in August and September, program delivery became disorganized. This indication of staff support did facilitate implementation of the program during the period when the second acting head nurse was forced to assume program co-ordination responsibilities.

Plans for continuation. The unit leaders (the new head nurse and the second acting head nurse), administration (the area supervisor), and the teaching nurses made plans for continuation of the program. It can be argued that the fact that these plans were made facilitated implementation.

First, the acting head nurse was appointed to be the permanent head nurse. Second, the teaching nurses were instructed to provide in-service about the program to the staff nurses. Third, a second program co-ordinator was appointed. Fourth, two new teaching nurses were added to the teaching team. Fifth, the teaching nurses were provided with two hours of development time per month.

In addition, although the participants knew that the program was "on hold" until September, when the new head nurse returned, they continued to make suggestions for improvements and additions. They suggested that more staff nurses should become involved in teaching the program, that two new lectures (death and pain) be added to the program, that the topic of stress be incorporated into all of the lectures, that a psychologist be added to the team, that teaching nurse meetings, team meetings, and staff meetings be held on a regular basis, that materials be prepared for the patients to take home, and that experts be available to the teaching nurses on a continual basis.

The nurses and the second acting head nurse continued to suggest that nothing could be done at the present time. However, it seemed that the knowledge of what could be done and that some plans had been made for the future, facilitated, or at the very least maintained, implementation during the nine month period.

In summary, five factors facilitated implementation of the planned programs. However, the only factor which appeared to have had a strong facilitative influence was the fact that the participants were sure the program was needed. During the summer of 1984, continuation of the program was threatened for the second time; the first being in November of 1983 when the teaching nurses said that they would not continue working on the program unless development time was provided. In August and September of 1984, it seemed that some of the teaching nurses had begun to "slow down" or "work-to-rule". It became abundantly clear that certain factors had inhibited implementation of the planned programs.

## Factors Which Inhibited Implementation of the Planned Programs

As indicated in Table 8.2, eight factors were evident in the data which appeared to have inhibited implementation of the planned programs.

Complexity. Implementation of the planned program, as had implementation of the first five programs (the Trial Run), proved to be a complex undertaking. Other departments continued to influence the activities on unit Y. The physiotherapists changed their class times from evenings to afternoons and conducted patient therapy sessions mornings and afternoons rather than only in the morning. No possibility now existed to move the nursing lectures to the daytime. The pharmacist requested that she be allowed to resume teaching the medication class and did so. Ruth then began to teach the stress lecture which she had not prepared. A program schedule was designed. However, one doctor admitted patients one week early and the next scheduled program had to be delivered ahead of schedule.

The nurses continued to teach and complete program development activities on their time off. Confusion occurred about funding. First, the Association treasurer was prepared to pay for teaching time but not planning time. The program co-ordinator understood that an understanding had been reached with the Association President and that the Association would pay for planning time. It became necessary for the first acting head nurse to intervene and straighten out the "mess" after the fact. In addition, the Association received a request for funding to produce a patient booklet from both the nursing and the physiotherapy department. According to the nurses, the Association wondered "why we can't get our act together?" Second, funds which had been designated to pay for two hours of planning and development time each month were used to orient two new teaching nurses to the program. The program paperwork was not done.

The work environment, as described by the second acting head nurse, was often busy and unpredictable making it almost impossible to schedule a specific planning or in-service time each day or each week. The nurses could not count on patients being admitted for the program. When the doctors were out of town, "off-service" rather than teaching patients were admitted to unit Y. Patients were either discharged early on long weekends or were discharged early to allow for the admission of emergency patients. Patient assignments were designed according to the division of workload, making a match of teaching patient to teaching nurse highly unlikely. Out-patients and in-patients attended the same class and appeared to have an inhibiting effect on each other in the group setting. The emergence of these intervening variables during delivery of the planned programs only added more power to the argument presented in Chapter 6 that program delivery was a complex process and that the complexity had an inhibiting influence on the implementation stage of the change process.

Leadership. During the nine month period implementation suffered from a lack of leadership. First, unit Y functioned without a permanent leader from January to September 1984. In May, the acting head nurse was selected to be the permanent head nurse. However, she immediately took a leave of absence. A supportive second acting head nurse was appointed. All the participants agreed that continuation activities had been put "on hold" until the new head nurse returned in the fall.

Second, the program co-ordinator, according to the second acting head nurse, "became very laid back." Inherent in statements made by the program co-ordinator and the teaching nurses was the idea that indeed the program co-ordinator had ceased co-ordination activities. Schedules indicating when the nurses would teach each class were not organized, assessment sheets were not handed out, and out-patients were not notified about the classes. The ward clerk and the second acting head nurse were forced to assume co-ordination of these activities. A requested in-service session for the staff nurses was not prepared and delivered.

All of the nurses agreed that while the program co-ordinator had personally produced a large volume of high quality work and was enthused, she did not have the necessary experience, characteristics, knowledge, and skill to be a leader. A second co-ordinator was appointed. The lack of leadership, both at the unit level and the program level, had a direct inhibiting effect on implementation of the planned program.

Materials production and delivery. The quality of materials which were produced and the speed with which they were produced did not meet the expectations of most of the nurses. Ann and Ruth thought the quality of the materials produced was superficial and mediocre. Beth did not complete developing the quackery lecture until just before she left in June. The material was not back from the word processor at the time that the new teaching nurse was preparing to teach the lecture for the first time. According to Ann, materials which were produced on the word processor were not of high quality and were late arriving back on the unit.

The teaching nurses exchanged lectures and reported that it was difficult to teach from material that someone else had prepared. Marg thought that all the nurses should attend the introductory class in order to get to know the patients.

Ann and Ruth were thoroughly frustrated that the time and money required to allow for further program development was not provided. On the whole, the lack of time and money for thorough program materials development and inadequate word processing resources inhibited implementation of the planned programs.

Antecedent conditions. The data revealed that many conditions which were now affecting implementation of the programs had existed prior to adoption of the change. First, the data revealed that prior conflict had existed between the physiotherapy department and the doctors, the doctors and the former head nurse, the director and the chief executive nursing officer, the chief executive nursing officer and the finance department, between groups of nurses on unit Y, and between individual nurses on unit Y.

Second, competition had existed between the physiotherapy profession and the nursing profession and between the medical profession and the physiotherapy profession. Third, the nurses thought that the physiotherapy department had always sought power and control and reported that the doctors had similar feelings about the physiotherapy department. It should be pointed out that the negative comments about the physiotherapy department appeared to be in relation to the one particular physiotherapist who had developed the old program. Fourth, the new head nurse in particular wondered why the nurses in hospital X were not more involved in "all-round" care of the patients. She thought that every other department had more control over patient care than did nursing. According to her, nursing should be at the center of patient care because they knew the patients and were with them 24 hours a day. Fifth, the reporting structure established for the former head nurse resulted, in part, in the area supervisor having what appeared to be a complete lack of knowledge about or interest in the teaching program on unit Y.

Finally, the data faintly suggested that although the nurses were genuinely interested in the program, the prime motivating factor for some of the nurses to join the teaching team may have been the need to ensure job security. Clearly the existence of these antecedent conditions had a profound inhibiting effect on implementation of the planned programs.

Multiple realities. As was reported in Chapters 6 and 7, each individual involved in the process had their own view of reality in relation to the change. The existence of these multiple realities continued to be evident during implementation of the planned programs. The Association, according to Ann, expected that more patients would attend the program, that patients from the out-patient clinics would attend the program, and that they would provide funding for teaching but not planning time.

The area supervisor had expected that the manual would be developed during the four week development period, that the program would not and should not become a priority on unit Y, and that Beth and Ann considered the opportunity to work on development activities to be a form of reward. The new head nurse and the second acting head nurse expected that materials produced would be available much sooner than was the case, that Ann and the teaching nurses would communicate with them on a continuous basis about the program activities, and that Ann would co-ordinate delivery of the program.

The physiotherapist expected that the department would be involved in a team effort to develop and deliver the program, that the teaching nurses would appreciate the efforts of the physiotherapy department to mount the original program, and that she would have continuous communication with the program co-ordinator about the program. The teaching nurses, on the whole, expected that the doctors would exhibit more interest, that the area supervisor would be more involved, that the staff nurses would be more interested, that the physiotherapy department would have less control, and that they [the teaching nurses] would be given more time and money to conclude the development activities which had been initiated and to initiate the plans which they had developed for continuation of the program.

The list of expectations could go on. However, the above examples are simply provided to illustrate that each individual and each group of individuals had expectations which were not met during implementation of the planned programs. What resulted was frustration on the part of Ann and Ruth. Beth left for personal reasons. Conflict developed between the program co-ordinator and the new head nurse, the program co-ordinator and the area supervisor, the physiotherapist and the teaching nurses and the new head nurse, unit Y and the Association treasurer, and some of the staff nurses and some of the teaching nurses. Delivery of the program became disorganized and the new head nurse moved in to remedy the situation. The existence of multiple realities and a profound lack of reflective conversation between and among the participants again threatened to bring implementation of the program to a halt.

Support of administration. As has been illustrated in the previous discussion, the presence of senior nursing administration (the director and the area supervisor) was not visible to the teaching nurses during implementation of the planned programs. It seems that while the teaching nurses may not have needed any form of direct intervention on the part of administration, they did want some recognition, some "pats on the back". The absence of such behaviors had a slight inhibiting effect on implementation.

Adoption process. One aspect of the adoption process had an inhibiting effect on implementation of the planned programs. Documentation about funding procedures was limited. As a result "the mess" over funding by the Association occurred. The conversation with the former head nurse revealed that one reason for the lack of documentation may have been that the chief executive nursing officer of hospital X intervened and the former head nurse could then no longer monitor the funding arrangements.

Staff development. Two of the teaching nurses attended a workshop on patient teaching during the nine months. On the whole, staff development activities related to the program for both the teaching nurses and the staff nurses were minimal during delivery of the planned programs and inhibited the stage of implementation.

## Summary

Data collection for the final phase of the study was completed on September 21, 1984. The teaching nurses had for nine months implemented the planned program. Beth had left the teaching team and was replaced by two staff nurses. Ann and Ruth were considering leaving the team. The first acting head nurse had been appointed permanent head nurse on unit Y. A second acting head nurse had been appointed to fill in while the new head nurse went on an extended leave of absence. Eight programs were implemented in the nine months. The area supervisor, one new teaching nurse, the second acting head nurse, the former head nurse, and the physiotherapist were provided with the opportunity to talk about their impressions of the change which had occurred. The head nurses and the three remaining teaching nurses provided updates on program activities and continued to describe the changes and problems that occurred as the planned programs were implemented. Five factors had emerged from the data which appeared to have facilitated implementation. These were:

1. Need for the program
2. External funding
3. Leadership
4. Support of staff nurses
5. Plans for continuation

The evidence indicated that eight factors had inhibited implementation of the planned programs. These were:

1. Complexity
2. Leadership
3. Materials production and delivery
4. Antecedent conditions
5. Multiple realities
6. Support of administration
7. The adoption process
8. Staff development

As in previous chapters, the factors when compared in Table 8.3, with those which Fullan (1982) had identified, appear to be very similar. When the factors are "unpacked", the results from Fullan's extensive analysis of the literature and the results fom the present study are almost identical. It seems that factor 14, the influence of government, did not have an impact on the process of change in the present study. However, one must remember, that it was the decision of the government to discontinue the policy of deficit funding which indirectly led to the delay of implementation in January, 1983. One factor appeared to have had a profound inhibiting effect on the process of change in the present study but does not appear to readily

Table 8.3

A Comparison of Factors Associated with Implementation of Planned Programs Identified in the Present Study with Those Identified by Fullan

| Factors Generated in the Present Study | Factors Generated by Fullan: 1982 |
|---|---|
| 1. Facilitating Factors | A. Characteristics of the Change |
| *1.1 Need | 1. Need for and relevance of the change |
| *1.2 External funding | |
| 1.3 Leadership | 2. Clarity |
| 1.4 Support of staff nurses | 3. Complexity |
| 1.5 Plans for continuation | 4. Quality and practicality of program (materials, etc.) |
| 2. Inhibiting Factors | |
| *2.1 Complexity | B. Characteristics at the School District Level |
| 2.2 Leadership | |
| *2.3 Materials production and delivery | 5. The history of innovative attempts |
| 2.4 Antecedent conditions | 6. The adoption process |
| 2.5 Multiple realities | 7. Central administrative support and involvement |
| *2.6 Support of administration | |
| *2.7 The adoption process | 8. Staff development (in-service) and participation |
| *2.8 Staff development | |
| | 9. Time-line and information system (evaluation) |
| | 10. Board and community characteristics |
| | C. Characteristics at the School Level |
| | 11. The principal |
| | 12. Teacher-teacher relations |
| | 13. Teacher characteristics or orientations |
| | D. Characteristics External to the Local System |
| | 14. Role of government |
| | 15. External assistance |

* Factors identified in present study which were also identified by Fullan to influence implementation.

"unpack" in Fullan's work. That is the factor of antecedent conditions. Clearly, the existence of antecedent conditions in this change process resulted in numerous conflict configurations with far reaching negative effects.

During the nine month period which has just been described, other informants were interviewed. These were the doctors, the staff nurses, and the patients. Their impressions of the program are presented in the next chapter.

# CHAPTER 9

# REACTIONS TO THE PROGRAM

## Introduction

Between April and September 1984, the investigator interviewed the four doctors of unit Y, five staff nurses of unit Y, and nine patients who had participated in the teaching program. Their reactions to the implementation of the program are described and discussed in this chapter. The chapter is divided into four sections. In the first section the reactions of the four doctors to implementation of the program are presented. The second section contains the opinion of the staff nurses about the teaching program. The patients' comments about the program are reported in the third section. Finally, a summary is presented.

## Reactions of the Doctors

The population of staff men on unit Y, the four specialists, were interviewed during May of 1984. All were asked to respond to the same introductory question: What is your opinion about the patient teaching program on unit Y? Three themes emerged from the data. The doctors discussed the purpose and objectives of the program, the problems which had emerged during implementation and some possible solutions, and finally, the outcomes of implementation. The three themes are now discussed.

### Purpose of the Program

All four doctors responded to the opening question by discussing the purpose and objectives of the program. According to the doctors, the patients would become more knowledgeable about their disease, would be able to look after themselves better, would become more independent, and would take a role in their own treatment:

> . . . better educated patients look after themselves better, the more likely they are to follow sound advice and the less likely they are to go off and seek magic remedies (Interview 36, Excerpt:1).
>
> . . . The teaching program has been very useful. It has given a component to patient care that we didn't have before. Patient education in this particular group of diseases, chronic diseases, is extremely important. There is so much that can be done and there are things the patients can do for themselves. This is one aspect of patient care that perhaps historically has not been very well done by the physicians. Therefore, an educational program is very important (Interview 37, Excerpt:1).
>
> . . . The program will instruct patients about their disease, allow them to understand the mechanisms of the disease, allow them to deal with problems more independently, and allow them to collaborate more effectively with the treatment regimens (Interview 40, Excerpt:1).

### Problems During Implementation and Possible Solutions Identified by Doctors

The doctors discussed five problems which had occurred during implementation. First, they confirmed the reports of the nurses, and unanimously agreed that scheduling the program to be congruent with the admission of patients was difficult. They felt that the program schedule would have to be more flexible and hoped that eventually every nurse would participate in teaching the program. One doctor wondered if the program could contain a number of blocks of content which were independent of ordering. The patient could then enter the program at any point and attend whichever block was being taught. Another doctor thought that the out-patients should be considered to be the major group of recipients and that the program schedule should be tailored to meet their needs, possibly outside of the hospital environment.

The second problem which occurred during implementation involved the teaching nurses. One doctor had slight reservations about the domain of nursing:

> . . . My only reservation is to ensure that people who are involved in the program maybe restrict their discussion to their particular areas of expertise. While I think it is quite reasonable that at some stage or other the sorts of medications and things like that be discussed with the patients, I think it's important that overall medical management of the patient should be left to the physician. It gets a little bit awkward when the patient comes back to you and says, "Well, in my class it was suggested I might have my shoulders injected" or something like that. Therefore, management, particularly the medical aspects must remain with the medical staff but I don't think that they are major problems (Interview 37, Excerpt:2).

One doctor confirmed that a third problem had existed, which had now been solved. As previously reported, the doctors had difficulty with the former head nurse: ". . . it was an unpleasant experience to come on to the unit (Interview 36, Excerpt:2)." However, the situation had improved "immeasurably" when a new head nurse was selected.

Another doctor made slight reference to a fourth problem. He thought: ". . . there had been friction between the doctors and the physiotherapists (Interview 41, Excerpt:1)."

Three of the doctors felt they had the opportunity to provide input into program planning and implementation activities. They also felt that they received adequate feedback about the program and that they only needed to ask if they required more information. One doctor made passing reference to a fifth problem. He wondered if the teaching nurses should be: ". . . more involved, better informed about the whole field of [the disease] (Interview 41, Excerpt:2)." He thought that perhaps: ". . . you could ship them off somewhere to exchange information (Interview 41, Excerpt:3)" with other nurses who were working with patients who had the same disease. He also thought that all the nurses should have more opportunities to interact with the doctors.

## Outcomes of Implementation

The doctors discussed three kinds of outcomes of program implementation. First, according to the doctors, the nurses benefitted from teaching the program:

> It's a very good educational process for the nurses. They can clearly understand what the goals and objectives of the treatment are and what is the rationale behind the methods of treatment that we're using (Interview 36, Excerpt:2).

The doctors thought nurses who were teaching the program were enthused, committed, and knowledgeable in the area of the specialty. The doctors did not communicate on a regular basis with the nurses. Except for one doctor, who had direct communication with Ann, the doctors did not know which nurses were teaching the program. One doctor thought: ". . . the behavior of the nurses as a whole has changed (Interview 40, Excerpt:2)." However, he had difficulty describing the changes in behavior because the doctors communicated only with the head nurse or nurse "in charge." The doctors thought that the nurse had clearly defined roles, as did the physiotherapists and the social workers and did not think that a new category of nursing personnel such as a 'clinical teacher' should be established: ". . . I regard my educational function to my patients as being an overall part of my job and I feel that nurses ought to feel that way too (Interview 36, Excerpt:3)." The doctors thought that: ". . . the ultimate supervisor in charge of the program has to be the ward chief, but anyone can coordinate it, an occupational therapist, a physiotherapist, even a nurse (Interview 37, Excerpt:3)."

The second outcome of implementation involved the benefits accrued to the patients. Three of the doctors felt that the patients were better informed, that the patient's fears had been allayed, that the patients became more compliant, and that the patients formed a bond with each other. The doctors could make these comments because they had talked to the patients. However, they were reluctant to directly correlate the observed changes in patient behavior with the program. They felt that a controlled experiment would have to be conducted to obtain conclusive evidence of program effectiveness but that a controlled experiment would be very difficult to conduct.

The third outcome of implementation, was that word about the program had spread to other hospitals, other areas of the province, and other parts of the country. Finally, although not an outcome of implementation, one doctor mentioned that the interviewing process had stimulated him to think about the program, and that perhaps he would contact Ann with some of his suggestions or concerns.

## Discussion of Doctors' Reactions

On the whole, the evidence supported Ruth's belief that the doctors were very interested in the program. The doctors indicated that implementation had and should be a team effort to operationalize the overall belief that better educated patients were better equipped to look after themselves than patients who had not taken the program. The ward chief should have the final say about program matters but the program could be coordinated by anyone on the team. According to the doctors, every team member had a clearly defined role and should function within the parameters of the role. They confirmed that doctors did not usually communicate with staff nurses, other than with the head nurse. Finally, the doctors felt that the program was having positive effects on the behaviors of both the nurses and the patients. However, they thought that such effects would be very difficult to measure.

## Reactions of the Staff Nurses

The investigator had intended to interview a purposive sample of unit Y staff nurses. Due to the difficulties encountered when attempting to arrange interviews on the unit, the investigator had to opt for interviewing a convenience sample of five staff nurses in April of 1984. One nurse had worked on unit Y in the old location and had moved with the unit to the new location. Two of the nurses had worked on the Unit since the relocation in 1982. Two of the nurses were recent graduates who had worked on the unit part-time for three months and whose employment status had been changed to full-time as of

April 1984.

One general introductory question was asked of each staff nurse: What is your opinion of the teaching program? Four themes were evident in the data collected from the staff nurses. The nurses described their personal interest in the teaching program, the problems which arose during implementation, the patient outcomes, and the staff nurse outcomes. Each theme is discussed in the following sections.

## Staff Involvement in the Teaching Program

None of the three nurses who had been on unit Y during the adoption stage had volunteered to join the original teaching team. The nurses gave a variety of reasons for their reluctance. First, all of the nurses were unsure about what would be involved in teaching the program. They felt that the plans for development and implementation of the program had been unclear and somewhat disorganized:

> It was so up in the air. There was nothing structured or planned. It was all of a sudden, "you're going to walk in cold turkey and teach a program." Nothing was laid out, no research was done. I wasn't interested in getting involved in that kind of a set up at all (Interview 30, Excerpt:1).

One of the three nurses did not feel confident teaching in a group setting. Two of the three nurses reported that they had been afraid of being forced to join the teaching team during the period of program adoption, while the third nurse reported that no pressure had been applied on the staff nurses to join the teaching team. One nurse had a disrupted personal life at the time of program adoption and had not been interested in joining the teaching team.

Of the three nurses, two were now interested in becoming involved in program activities. One would like to teach, but was planning to leave the unit. The second would help with implementation activities, but did not want to teach. The third staff nurse was not interested in becoming involved in program activities. Of the three nurses, one had attended two of the lectures. The others reported that they had a basic understanding of the program but that they had not attended any classes and had not read the program manual. Two of the three nurses communicated on a regular basis with a nurse on the teaching team and therefore felt that they had been kept up to date on program activities.

Two of the three nurses made comments regarding the motivation of the original teaching nurses to join the teaching team. The earlier reports, of the three head nurses and Ruth, that some of the nurses had joined the teaching team during the time of "budget cuts" to secure their jobs were confirmed by the nurses.

When interviewed in April, the two staff nurses, who were recent graduates, expressed interest in joining the teaching team. As indicated in Chapter 8, these two staff nurses subsequently did join the team. These staff nurses wanted to join the the team to learn more about the patients, to better help the patients, and to become more involved as a team member in the activities of unit Y. One of the recent graduates wanted to gain some patient teaching experience because she thought that it might be personally satisfying and that a notation of such experience on a resume might be an advantage when she was considered for future jobs.

## Problems During Implementation as Identified by Staff Nurses

The nurses confirmed that some problems had occurred on unit Y during development and implementation of the program. First, there was unanimous agreement among the five nurses that the physiotherapy department had caused problems. The staff nurses were aware of the "power struggle" between the physiotherapy department and the nurses. The physiotherapy department, also, were "always changing their minds." The schedules of the sessions for individual patients and the physiotherapy lectures were often disorganized, changed or cancelled. Porters would arrive for patients at unscheduled times, or would arrive for the wrong patients thereby disrupting the routines of the staff nurses. Times for lectures would be changed, again resulting in confusion on the unit: ". . . physio is a frustration every day (Interview 30, Excerpt:2)." A second nurse was annoyed by the confusion caused when classes were cancelled: ". . . everybody was annoyed and it's a real bother (Interview 33, Excerpt:1)."

The second problem concerned scheduling the nursing lectures and co-ordination of program delivery activities. The staff nurses were aware that it was difficult to schedule the nursing lectures. Class times and class nights would often be changed or cancelled at the last moment. It often became necessary for the staff nurses to inform the patients of the changes and to answer questions from the patients about the reasons for the changes. One staff nurse became annoyed: ". . . it's annoying because we're the ones that the patients come to with their problems and I didn't know anything about the scheduling (Interview 31, Excerpt:1)." Another staff nurse reported: ". . . We're expected to know when the class is and make sure the patients get there. Sometimes you just don't have time for it. I figure that's probably up to the teaching nurses (Interview 31, Excerpt:2)."

The third problem of which the staff nurses were aware concerned funding by the Association. The staff nurses were aware that the teaching nurses had not been paid and that the Association would not fund planning time. Although the problem did not directly affect the staff nurses, they were aware of the frustration of the teaching nurses: ". . . I would be frustrated with them too. They had put so much work into it, on their days off and teaching after a 12-hour shift, and then not getting paid for it (Interview 33, Excerpt:2)."

Four of the staff nurses did not confirm the existence of a fourth problem which had been identified by the teaching nurses. The four staff nurses did not confirm the earlier reports of the teaching nurses that the planning and development period had caused dissension between the staff nurses and the teaching nurses. The staff nurses knew that the teaching nurses had been paid for that time and assumed that the teaching nurses had worked hard during the development period:

> It didn't bother me. They were reimbursed for it. They knew what they were doing. They weren't going to sit here all day and twiddle their thumbs. They had quite a bit of work to accomplish (Interview 33, Excerpt:3).

However, one nurse felt that the office time was wasted and misused:

> It was wasted and misused. I resented the fact that they were being paid for that time and the job wasn't being done. I don't mind people having office time if something productive is being done. We'd see them drift in at different hours, dressed in street clothes, and taking coffee breaks. I'm not saying they weren't entitled to that, but we just didn't see anything being accomplished (Interview 30, Excerpt:3).

This staff nurse reported that she was adversely affected, particularly if she was "in charge", when a teaching nurse, while on duty, unexpectedly left the floor to work in the office on program activities. These unexpected departures from the floor by a teaching nurse meant that the staff nurse would have to reorganize her own schedule which resulted in the overall disruption of activities on the unit. This same staff nurse confirmed reports of the teaching nurses that dissension had occurred among the teaching nurses during the planning and development period. She thought that some of the teaching nurses had been frustrated by the lack of leadership and lack of direction. In addition, certain nurses could not get along with each other. As a result, some of the teaching nurses were losing interest in the program. She thought this was unfortunate:

> Some of them have lost interest and aren't giving their all to it. That is a shame because it's another area for resentment. They volunteered for the program. They started doing it and were paid for it. They made a commitment. They should carry it out. If they don't want to do it anymore, they should resign from the group and help find a replacement (Interview 30, Excerpt:4).

The existence of a fifth problem that was identified by the teaching nurses was not confirmed by the staff nurses. The reports of the five staff nurses did not confirm the reports of the teaching nurses that delivering a class during the evening while the teaching nurse was working on the floor had caused problems. The staff nurses however did admit that problems could occur if the floor was busy when the teaching nurses left to teach a class.

The staff nurses confirmed, in part, a sixth problem which had been identified by the teaching nurses. The teaching nurses had reported that the staff nurses were not interested in joining the teaching team, in taking part in program related activities on the unit, or in attending the lectures. Only two of the five staff nurses reported that they had attended lectures. Most had not read the lecture materials. One staff nurse reported that it was the responsibility of the teaching nurses to coordinate delivery of the program. One staff nurse was not interested in taking part in the program activities. Four of the five staff nurses, however, reported that they had become more interested in the program and would now consider taking a more active role in related activities.

The comments of one staff nurse shed some light on why the staff nurses initially appeared disinterested in becoming involved in the program. First, the staff nurses, during the adoption period, were afraid of group teaching and were also afraid of being forced to teach the program. This fear seemed to have originiated in the minds of the nurses, in part, because of the attitude of the former head nurse about the meaning of professional nursing and the necessity for nurses to pursue higher education. The staff nurses thought that due to the focus of the former head nurse, she had become too involved in the activities which required her to be away from the unit and away from bedside nursing. The staff nurse was afraid that: ". . . if we get too involved in this program we're going to be pulled away from the patients (Interview 30, Excerpt:5)." Second, the staff nurse also wondered if attending program related lectures and in-service presentations might threaten the staffing patterns and jobs of the nurses on unit Y:

> Administration considers us a Mickey Mouse unit. We don't always have patients on respirators and with a thousand tubes, so nursing-wise, they don't think we're busy. But it's exhausting working here. The girls feel guilty leaving the patients to go to inservice. Plus it's a way of them [administration] retaining power over us. When the budget was bad, they were "pulling" us. Even now they're "pulling" us. They question everything we do, our staffing patterns. The supervisors come on evenings and if we're sitting down, they'll think we're not busy and question what we're doing. So by saying "we're too busy to go to a lecture," we're in a way justifying our jobs, saying "We're needed." It's a complex thing (Interview 30, Excerpt:6).

The staff nurses discussed a seventh area which had been identified as a problem by the new head nurse and some of the teaching nurses. The nurses thought that the staff nurses had not been given sufficient information about the program and needed an opportunity to provide input to the program. Most of the staff nurses thought they had received or had the opportunity to receive sufficient feedback about the program activities and to provide input into program activities. In particular, the two recent graduates felt that Ruth, Beth and Ann were "more than willing" to describe the program and to encourage the new graduates to become involved in teaching the program. Only one of the five staff nurses thought that staff nurse input had not been solicited and that the staff nurses had not been provided with any feedback about program activities. However, all of the staff nurses thought that more feedback about the program should be included in regular staff meetings.

The staff nurses briefly discussed three other areas which had been identified as problems by the teaching nurses. According to the staff nurses, they only communicated with the doctors when they were "charge nurse." However, all five thought that the doctors were interested in the program. The staff nurses also confirmed the reports of the two head nurses that although program implementation had begun in June of 1983, it really did not exist until the fall of 1983. Finally, one staff nurse confirmed that a difference did exist between the diploma graduates and the baccalaureate graduates. The diploma graduates were concerned with the practical aspects of patient care, while the baccalaureate graduates were concerned with research. She also thought that: ". . . some nurses were made for bedside nursing and some were made for teaching (Interview 30, Excerpt:7)."

## Patient Outcomes Identified by Staff Nurses

According to the five staff nurses the program was needed and was worthwhile. They recounted specific incidents, as had the teaching nurses, of particular patients who needed the program and needed to be referred to a specialist:

> There's farmers that are crying. They can't take care of the farm, they can't lift the buckets. There's housewives that have problems doing housework, taking care of their kids, having sex with their husbands. They're confused about their meds. They obviously don't want to go home. These patients are hard to care for. They act out at you the nurse. They're taking out their frustrations on you. I can see it

> as clear as day that these patients shouldn't be managed by a general practitioner. They should be referred to a specialist and they should go through the program (Interview 30, Excerpt:8).

The nurses described the behaviors of the patients who attended the program and thought that these behaviors were different than the behaviour of patients who did not attend the lectures:

> . . . They ask more questions. They seek clarification about something that was said in class (Interview 31, Excerpt:3).
>
> . . . They're more knowledgeable. They've said the program has really helped (Interview 33, Excerpt:4).
>
> . . . They read their handout and they ask questions. They're not as prone to outbursts. They're more relaxed (Interview 30, Excerpt:9).
>
> . . . They're eager to learn more about their disease. They said they don't feel so alone (Interview 32, Excerpt:1).
>
> . . . They're more interested in their medications. They ask for a social worker. They become more open. They seem to confide in you. They understand what we expect from them. They ask the doctors questions. Other patients won't do those kinds of things. I can tell they're learning (Interview 31, Excerpt:1).

## Staff Nurse Outcomes

The five staff nurses described the effects, on themselves, of implementation of the program. Four of the nurses thought that they should become more knowledgeable about the program because: ". . . we need to reinforce what is taught (Interview 30, Excerpt:10)." Four of the nurses reported that they found the program interesting and that in order to reinforce and clarify what had been taught in a class, they themselves had to learn more about the disease:

> . . . It's interesting. Quite often we have to go and look something up because there are things that we're not sure about. I'm thinking more about the specialty and the disease now because I know the patients are going to be asking questions (Interview 31, Excerpt:4).

One nurse explained that, although as staff nurses they did not teach in the program, they did inadvertently become involved in implementation:

> It's a small unit. Even if you don't want to become involved, you are involved. Just by listening, by adding your input. You become involved without realizing it. It's around you all the time (Interview 33, Excerpt:5).

One nurse explained that she treated the patients who were in the program differently than the patients who were not in the program. In addition to clarifying and reinforcing knowledge, she asked the program patients different kinds of questions:

> I find I'm asking them more questions. I ask them different kinds of questions. I kind of push, "What did you learn in your lecture? What did you think was wrong or right? How do you feel?" With the other patients I have to start from the beginning and ask them "How much do you know about your disease (Interview 34, Excerpt:2)?"

She also reported that she felt more confident about working with the program patients after she had talked to the teaching nurses about the content of the program.

One recent graduate reported that: ". . . I felt left out of the program activities on the unit. I think all new nurses on this unit should be oriented as soon as possible to the program (Interview 32, Excerpt:2)." She needed to know more about the program in order to confirm and reinforce the content which the teaching nurses had taught. She was going to join the teaching team.

## Discussion of Staff Nurses Reactions

The evidence in the data indicated that the staff nurses, on the whole, were interested in the teaching program. Although none of the original staff nurses had volunteered to join the teaching team, they now, after one year of implementation, were interested in becoming involved in program activities. Three were interested in joining the teaching team, and as is indicated in this report, the two recent graduates did so. Three reasons were given by the staff nurses for not joining the original teaching team during adoption. First, some of the nurses had personal commitments and time constraints which prevented them from becoming involved. Second, some of the nurses felt that during the adoption stage the mechanics of program implementation and the content of the program had not been clearly defined or developed. Finally, it seemed that most of the staff nurses were not confident of their ability to teach in a group setting, were afraid of being forced to take part in teaching the program, and were afraid that involvement in the teaching program might take them away from bedside nursing.

The staff nurses confirmed the reports of the teaching nurses that the program was worthwhile and were convinced that they could observe changes in patient behavior which could be attributed to the program. Four of the staff nurses indicated that they had inadvertently become involved in program activities. It became necessary for the staff nurses to reinforce classroom content and to answer specific patient questions during the course of daily nursing care on unit Y. As one staff nurse commented: ". . . we did become involved. It was all around us." The staff nurses found that they began to have different expectations of the program patients, that they began to make different observations of the program patients, and that they asked different questions of the program patients than of the non-program patients.

The staff nurses responded to the demands placed on them by the program activities in a number of ways. They talked to the teaching nurses about the program content and found that it was necessary to seek out answers to specific patient questions (e.g. about medications) in reference books on the unit. However, most of the nurses did not attend the lectures or thoroughly examine the program materials. It did appear that the staff nurses, except for the two recent graduates, were not willing to invest their own time to learn about the content of the program. Also, as one staff nurse indicated, they were reluctant to attend in-service activities for fear that the unit would appear over-staffed in which case staff numbers on unit Y would be reduced and/or staff would be 'laid off.'

The staff nurses did confirm the reports of the teaching nurses that problems had occurred during implementation of the program. The physiotherapy department had caused problems, the scheduling of classes had been difficult, confusion had occurred over funding, and leadership had been somewhat lacking during both the implementation and the planning stages of the change. The staff nurses discussed the impact of these problems on the work of the staff nurse on unit Y.

The staff nurses, as a group, did not confirm the reports of the teaching nurses that teaching the evening classes while on duty had caused problems, that the doctors were not interested in the program, or that the staff nurses were not providing input and were not receiving feedback about the program. All except one staff nurse thought that they as staff nurses had sufficient opportunity to provide input and had received adequate feedback about program matters. However, they did think that they should have known the details of the program sooner and that a program progress report should be on the agenda of regular staff meetings.

As a general statement, one could suggest that there was only 50 per cent agreement between the perceptions of the teaching nurses about the staff nurses' perceptions of the program and the reality of the staff nurses' perceptions of the program. Again one must conclude that misunderstandings between the staff nurses and the teaching nurses would have been reduced had the opportunity and leadership been provided for the two groups to engage in reflective conversation which allowed each to discover the other's individual meaning of the change.

## Reactions of the Patients

A profile of the patient population which attended the teaching program between June 1983 and June 1984 is provided in Table 9.1. Documentation about the patients was provided by the program coordinator. It must be remembered that record keeping systems were not designed until January of 1984. Therefore, the amount of detail

Table 9.1

Profile of Patients Attending Teaching Program Between June 1983 and June 1984

| Characteristics | | n |
|---|---|---|
| 1. Residence | N = 60 | |
| rural | | 35 |
| urban | | 23 |
| unknown | | 2 |
| 2. Gender | N = 60 | |
| female | | 45 |
| male | | 15 |
| 3. Residence by gender | N = 60 | |
| urban male | | 3 |
| urban female | | 20 |
| rural male | | 12 |
| rural female | | 23 |
| unknown female | | 2 |
| 4. Age | N = 30 | |
| under 20 | | 1 |
| 20 to 29 | | 6 |
| 30 to 39 | | 4 |
| 40 to 49 | | 3 |
| 50 to 59 | | 7 |
| 60 to 69 | | 6 |
| 70 to 79 | | 2 |
| 5. Family member attended class | N = 34 | 14 |
| 6. Years that disease has been diagnosed | N = 9 | |
| less than 1 year | | 2 |
| 1 to 5 years | | 2 |
| 6 to 10 years | | 2 |
| 11 to 20 years | | 2 |
| more than 20 years | | 1 |

in the information which was collected about the patients, particularly those who attended the first programs, ranged from non-existent to fair. The following data should therefore be regarded with extreme caution and are provided to give a general profile of the patients who attended the program. In spite of limited detail, the records indicated that 60 patients attended at least one nursing lecture in the one year period, that slightly more (35) patients attended from the rural area than from the urban area (23), and that 45 females in contrast to 15 males attended the program. The ratio of females to males attending from the urban area was 6.6:1; whereas the ratio of females to males attending from the rural areas was 2:1. Records about age were kept on only one-half of the patients. The age of the patients attending the program ranged from 19 to 72 years. Of the 30 patients, seven were in their 20's or younger, four were in their 30's, ten were between 40 and 59 years of age and nine were over 60. Records about how many patients had family members who attended the program were kept only after January of 1984. Of the 34 patients attending the program between January and June 1984, 14 patients had a family member who attended at least one of the three nursing classes.

In-depth recorded interviews were conducted with nine patients (15 percent) who attended the program. Patients who participated in the program were selected to be interviewed according to a modified stratified sampling technique. Because of limited time and limited money, the investigator selected those patients who resided in the urban center. The sample was further stratified to reflect the four geographic areas of the city, to reflect a sample gender ratio congruent with the gender ratio in the program patient population, and to reflect a sample age ratio congruent with the age ratio in the patient population. The sampling procedures were further influenced by two other factors. Due to the gender and safety requirements of the investigator, only males who had a female residing in the home were selected to be interviewed. In addition only patients who had attended at least three of the nursing lectures were included in the possible group to be interviewed. A preliminary telephone interview with each possible candidate was conducted prior to making the final selection to determine: how many classes the patient had attended, if the patient could speak and understand English, if any family member had attended the program, and if the patient was willing to take part in a recorded interview and to sign an informed consent. Eleven possible candidates emerged from the sampling procedures. In-depth interviews were conducted with nine patients during August and September of 1984.

A profile of the patients who were interviewed is presented in Table 9.2. Eight females and one male were interviewed (Table 9.2, #1). Only one patient lived alone (Table 9.2, #2). Five patients were married (Table 9.2, #3). A family member of only three patients attended the classes (Table 9.2, #4). Five of the nine patients attended the program between June and December 1983 (Table 9.2, #5). Six patients were referred by their general practitioner to the specialist, who in turn, suggested that the patient attend the program. One patient had read about the program in a magazine and another patient had heard about the program on a radio talk show.

Table 9.2

Profile of Urban Patients Who Attended the Program and Were Interviewed
N = 9

| Characteristics | n |
|---|---|
| 1. Gender: | |
| male | 1 |
| female | 8 |
| 2. Lived with another person in the home? | |
| yes | 8 |
| no | 1 |
| 3. Marital status: | |
| married | 5 |
| single | 2 |
| other | 1 |
| 4. Family member attended at least one nursing class: | |
| yes | 3 |
| no | 6 |
| 5. Attended program: | |
| June to December 1983 | 5 |
| January to June 1984 | 4 |
| 6. Length of time has been diagnosed as having the disease: | |
| less than one year | 2 |
| 1 to 5 years | 3 |
| 6 to 10 year | 1 |
| 11 to 20 years | 1 |
| more than wo years | 2 |
| 7. Age: | |
| under 29 | 1 |
| 30 to 39 | 1 |
| 40 to 49 | - |
| 50 to 59 | 4 |
| over 60 | 3 |
| 8. Had attended former program? | |
| yes | 1 |
| no | 8 |

Table 9.2 (continued)

| Characteristics | n |
|---|---|
| 9. Part of program first described by patient: | |
| physiotherapy | 5 |
| nursing | 3 |
| no comment | 1 |
| 10. Program is needed? | |
| yes | 8 |
| no | - |
| not sure | 1 |
| 11. Nursing lecture that was most beneficial: | |
| introduction/film | - |
| stress | 1 |
| medications | 6 |
| quackery | 5 |
| not helpful | 1 |
| 12. Nursing lecture least beneficial: | |
| introduction/film | - |
| stress | 6 |
| medications | - |
| quackery | - |
| not helpful | 2 |
| 13. Handouts were valuable and regularly used: | |
| yes | 4 |
| no comment | 5 |
| 14. Primary reasons for admission to hospital: | |
| to take the program | 4 |
| for medical reasons | 4 |
| no comment | 1 |
| 15. Have done prior reading about disease: | |
| yes | 6 |
| no | 1 |
| no comment | 2 |
| 16. Who I went to with questions: | |
| any staff nurse | 4 |
| teaching nurses | 3 |
| senior nurses | 1 |
| no comment | 1 |

Table 9.2 (continued)

| Characteristics | n |
|---|---|
| 17. Go to a specialist: | |
| yes | 7 |
| no comment | 2 |
| 18. Recommend that others take the program: | |
| yes | 8 |
| no comment | 1 |

Both patients requested that they be referred to a specialist specifically to take the program.

Of the nine patients, five had the disease for five years or less (Table 9.2, #6). Two of the nine patients had the disease for more than twenty years. One patient was under 29 years of age, one was between 30 and 39 years of age, four patients were between 50 and 59 years and three patients were over 60 years of age (Table 9.2, #7).

Table 9.2 (#8) indicates that only one of the nine patients had attended the former program. This particular patient had the disease for over twenty years. She liked the new program better than the old program:

> Patient #5: I think the program is a lot better now.
> I: What was it that was better?
> Patient #5: They had us do a lot of things. How to pick up things up with your toes and different exercises you could do with your feet and hands. I think it's the participation of all the patients that makes it. Everybody sort of jokes and laughs and it's really quite a carefree thing, you know. I enjoyed the whole thing. And the nurses. There were all those different classes that we took that we had never taken before. You stayed right on your floor to do them. I thought that was really good. It was something to look forward to, those meetings that took place. They were very interesting. The nurses were almost as if they were specializing in it [the disease]. They were so interested. Most of the nurses that you got when you were in the other time, I wouldn't say that they didn't take an interest, but they didn't take the complete interest that the nurses do now in that ward there (Interview 9, Excerpt:1).

Also indicated in Table 9.2 (#9) and as is illustrated in the above excerpt, five of the patients, when discussing the program, mentioned the physiotherapy and occupational therapy component of the program first and the nursing component second. The patients described the physiotherapists and occupational therapists as: ". . . excellent, thorough, dedicated, and happy." They described the physiotherapy component of the program as: ". . . especially important and most helpful." One patient however, found the therapy sessions tiring and would have preferred a day of rest during the week.

Three of the patients described the nursing component of the program first and described the nurses as: ". . . knowledgeable and caring." The nursing lectures were: ". . . something to look forward to, a break in the routine, the most important part of the program."

One patient who took part in the program as an out-patient, attended only the nursing lectures. He found that he did not know the other patients and that he found it difficult to "expose himself" to strangers in the group setting. He had expected to receive in-depth detailed knowledge about why he had the disease, what the disease was doing to his body, what part diet played in the disease, what alternative treatments, in addition to medications, might be available, how to better make his family understand his difficulties and how to develop more self-awareness and gain more control over his life. This man had the disease for 16 years, and at the present time was experiencing serious problems identifying a medication which would stabilize and control his symptoms. He was frustrated and depressed. Over the years, he had read extensively and at this particular stage of his disease did not think that the program had been very helpful:

> Patient #7: I don't feel that I got that much out of the lectures. I knew quite a bit about the disease anyway. I wouldn't want to communicate that I didn't learn anything in those lectures. But, I don't know whether it helped me that

> much. The one on drugs was informative and assisted you in being aware of certain things that you don't know. I think some questions were raised in the lecture that even the lecturer wasn't too clear on. I got the feeling that the nurses are not aware of what those drugs can do to you. But I don't know whether that's a fair conclusion. I would like to hear what the authorities are saying about these pills. I get the feeling at times that they are not levelling with me.
>
> The one on stress more or less pointed out that if you're feeling rough take it easy and deep breathe. There's more to it than that. I find this disease has got between me and my wife and me and my children. I'm just thinking that somewhere that should be worked out. I'm saying that I would like some assistance with understanding. I guess what I'm saying is, "does battling [this disease] have something to do with developing a greater knowledge of yourself and how to relate to other people or is this battle simply with [the disease] and dealing with pain and taking medications?" Somehow you can't divorce those two things (Interview 51, Excerpt:1).

However, as is indicated in Table 9.2 (#10) and in spite of the reactions of this one patient to the program, the other eight thought the program was very beneficial and was needed.

They talked about the program as being multidisciplinary, incorporating the expertise of the physiotherapy, occupational therapy, social services, medical, and nursing professions. Of the nursing lectures, the patients most frequently reported (Table 9.2, #11) that the medication lecture and the quackery lecture were the most useful and confirmed the reports of the teaching nurses that the stress lecture was the least useful (Table 9.2, #12). Four patients reported (Table 9.2, #13) that they regularly referred to the material which was handed out during the program. Five patients (Table 9.2, #14) were initially admitted to the hospital for medical reasons, primarily for stabilization of medication treatment, and while in hospital subsequently attended the program. Three patients were admitted to the hospital primarily to attend the program. Seven of the nine patients (Table 9.2, #15) confirmed the reports of the teaching nurses that they had done extensive reading about the disease. Three patients reported that they did not need the information on economic assistance which had been included in the social services lectures. Four patients (Table 9.2, #16) reported that they would seek out the teaching nurses when they required answers to questions, while three patients thought that all of the staff nurses on unit Y were very knowledgeable and able to provide answers to most questions.

As indicated in Table 9.2 (#17), seven patients thought that a person who suspected their symptoms might be an indication of the chronic disease should immediately request a referral to a specialist. It is of note that three of these seven patients, after being assessed and being put on a stabilization program by a specialist, then requested that the week-to-week management of the disease be coordinated by their general practitioner. They continued to visit the specialist on a regular basis, but did not want to go through the "hassles" of the clinic situation to have on-going blood tests and to receive the accompanying doses of medications. According to these patients, the clinic environment was too impersonal and the procedures (blood-tests, waiting for results, seeing the doctor, and receiving the medications) took far too long. These patients found it much more expedient and more personalized to visit their family doctors for this routine medical care. However, eight of the patients did strongly recommend (Table 9.2, #18) that people with the disease should attend the program.

In addition to the above comments which the patients made about the program, two reported that the three weeks of hospitalization had provided them with a much needed rest, three reported that their fear and anxiety about the disease had decreased, and one reported that the program had refreshed her knowledge about the disease.

The patients talked about changes which had occurred in their own behavior and which they had attributed to the program. These actual learner outcomes are listed in Table 9.3. Finally the patients discussed some additions or changes which should be made to the program. The suggestions are listed in Table 9.4.

### Discussion of Patient Reactions to the Program

Based on the evidence obtained from the patients during the interviews, a number of observations made by the nurses about the patients were confirmed. First, the patients did think the program worthwhile and in fact recommended the program to people who they knew had the disease and to people they suspected may have the disease. Second, the patients were adamant in their belief that people with the disease should be assessed and treated by a specialist. The two patients who had lived with the disease over 20 years were convinced that they would not have developed as many physical problems and that they would have had a better quality of life had they been under the care of a specialist from day one and had they attended the program soon after being diagnosed. What is interesting to note is that some

Table 9.3

Actual Learner Outcomes Reported by Patients Who Were Interviewed and Who Attributed Outcomes to the Program
N = 9

| Outcomes | | n |
|---|---|---|
| 1. | Own behaviour | |
| 1.1 | I recommend others to see a specialist | 7 |
| 1.2 | I regularly do my exercises | 7 |
| 1.3 | I protect parts of my body | 5 |
| 1.4 | I take frequent rest periods | 5 |
| 1.5 | I better understand my medications | 5 |
| 1.6 | I better understand my disease | 3 |
| 1.7 | I accept my disease | 3 |
| 1.8 | I take short cuts when doing housework | 3 |
| 1.9 | I split up my work | 3 |
| 1.10 | I feel I can help myself | 3 |
| 1.11 | I gained a sense of hope | 3 |
| 1.12 | I attended an Association meeting | 1 |
| 2. | Behavior with other patients | |
| 2.1 | We formed a bond | 8 |
| 2.2 | I talked with others who understand my disease and about my pain | 7 |
| 2.3 | I learned things from other patients | 3 |
| 2.4 | I taught other patients about coping with the disease | 2 |
| 3. | Behavior with family and friends | |
| 3.1 | I refuse advice about quackery | 4 |
| 3.2 | My husband and children do more work | 2 |

Table 9.4

Program Additions or Changes Suggested by Patients
Who Were Interviewed
N = 9

| Additions/Changes | n |
|---|---|
| 1. Content | |
| 1.1 Include something for the elderly, for the young, and for those living alone | 3 |
| 1.2 Include more on side effects of medications | 2 |
| 1.3 Include something on diet and nutrition | 2 |
| 1.4 Include a session by a psychologist | 2 |
| 1.5 Beef up the stress lecture | 2 |
| 2. Delivery | |
| 2.1 Involve more family members | 3 |
| 2.2 Give classes in out-patient clinic | 3 |
| 2.3 Advertise the program more widely | 2 |
| 2.4 Show more films | 1 |
| 2.5 Provide a list of books recommended by the doctors | 1 |
| 2.6 Provide more rest periods | 1 |
| 2.7 Decrease amount of repetition between physio and nursing material | 1 |
| 2.8 Involve newly diagnosed patients in progam sooner | 1 |
| 2.9 Include more discussion sessions with the teaching nurse | 1 |
| 2.10 Put program patients in the same room | 1 |
| 2.11 Have a teaching nurse look after program patients | 1 |
| 3. Delivery to out-patients | |
| 3.1 Provide review and up-date classes | 5 |
| 3.2 Provide a heated pool in city | 4 |
| 3.3 Provide more classes for out-patients | 4 |
| 3.4 Establish more support groups for out-patients | 3 |
| 3.5 Provide more personalized and more comprehensive care in out-patients clinic | 3 |
| 3.6 Provide program in rural areas | 1 |

patients had to bring the existence of the program to the attention of their family doctor and had to subsequently request that they be referred to a specialist in order to take the program. What is also interesting is that of the seven patients who had the disease for more than one year, only one patient reported that they had attended the former program or received any instruction about the disease.

Third, the patients were able to describe changes which they had made in their activities of daily living, confirming the previous reports of the teaching nurses (Table 6.4 in Chapter 6). They also made suggestions for changes and additions to the program (e.g.: diet, psychologist, match of teaching nurse to program patient, reinforcement, revision) which were congruent with suggestions made by the teaching nurses.

Fourth, the patients confirmed the beliefs of some of the nurses that the program was multidisciplinary. However, coming as somewhat of a surprise to the investigator, was the finding that over 50 percent of the patients interviewed first began to talk about the physiotherapy component of the program when they were asked about their opinion of the program. It seemed that the teaching which was done by the physiotherapists was more concrete and specific (i.e.: use of heat and cold, use of specific exercises, lessons on how to walk, sit, lift, and work in the kitchen, etc.) than the more nebulous content areas (e.g. stress) which the nurses were teaching. The main attraction of the nursing lectures, in addition to the knowledge about drugs and quackery, which the patients received, appeared to be the social component the bonding of the patients and the formation of a support group. The patients enjoyed discussions with the teaching nurses and in particular with the other members of the group. It seemed that the teaching nurses and the program in general took on a facilitative role in initiating a group support kind of experience for the patients; an experience with which they were not previously familiar and which they both wanted and needed to continue.

Sixth, the patients confirmed the belief of one particular doctor that the program should be expanded or modified to reach a greater number of out-patients. The patients were not pleased with the situation in the out-patients clinic and made creative arrangements on their own to avoid becoming dependent on the clinic for on-going assessment and regulation of medications.

Finally, the patients, on the whole, were confident that most of the nurses on unit Y were competent and knowledgeable with respect to the chronic illness. They thought that the nurses had "specialized" in this disease.

## Summary

In this chapter the reactions of four doctors, five staff nurses, and nine patients to implementation of the teaching program for patients with the chronic illness have been described. Interviews were conducted between April and September 1984 with the population of staff doctors on unit Y, a convenience sample of staff nurses on unit Y, and a stratified sample of patients who had attended the program on unit Y.

The staff nurses confirmed the beliefs of the teaching nurses that the program was worthwhile and was needed. Most of the staff nurses were interested in becoming involved in implementation of the program. Two of the staff nurses joined the teaching team. Two others were still reluctant to teach the program, but wished to be included in program related activities. The staff nurses, as had the teaching nurses, described changes in patient behavior which they believed could be attributed to the program.

The four doctors were supportive of the program. While they did not see their role as necessarily being one of active involvement in implementation, they did think that they had received adequate feedback about the program and that they had the opportunity to provide input about implementation at any time. They believed that the program had stated purposes and goals which all members of the multidisciplinary team should strive to meet within the parameters of clearly defined roles. They saw themselves as the final authority on program matters, but felt that any one of the disciplines could coordinate the program. Although the doctors were unwilling to state conclusively that the program had made a difference in patient behavior, they had 'a feeling' that the program was achieving its intended purpose and that the program had produced intended patient outcomes.

The patients confirmed the reports of the teaching nurses, the staff nurses and the doctors that the program was worthwhile, was indeed needed, and was in fact almost a necessity for people who had the chronic disease. They thought the patients should attend the program soon after being diagnosed, that patients should be cared for by a specialist on a regular, if not a week-to-week, basis, that these kinds of programs should be more widely advertised, and that this kind of program should be made available to patients in the rural areas. The greatest benefit in addition to the knowledge which the patients gained from the physiotherapists, occupational therapists and nurses, seemed to be that of group understanding and group support. The patients, after being discharged from hospital, had maintained contact with fellow patients whom they had met during the program.

In terms of patient outcomes, there can be no question that the implementation of the program was a great success. However, as has been illustrated throughout this study, the process of implementation of the program had proved to be a difficult and complex endeavour.

In the final chapter, a summary and a discussion of the conclusions and recommendations about the process of change is presented.

# CHAPTER 10

# CONCLUSIONS, RECOMMENDATIONS, AND REFLECTIONS

This study was designed to describe and explain the process of change on one particular nursing unit. One general research question was asked: What happened when four staff nurses on unit Y in a large Canadian hospital attempted to develop and implement a teaching program for patients with a chronic illness? While the nursing literature insists that change is a process, not an event (Stevens, 1980; Mauksch, 1981; Lancaster, 1982), and while numerous articles and reports have appeared in the nursing literature about the process of change (Dean, 1979; Spradley, 1980; Ahmed, 1981; Hendrix, 1982; McGill, 1983; Crane, 1983; Munroe, 1983), there was no evidence to indicate that any studies of the scope and magnitude of the present study had been conducted. No study had examined the process of the change from its inception through implementation across a substantial period of time. No researcher had undertaken a study in which factors which influenced the change process were allowed to emerge rather than being determined in advance. The present study was conducted in an attempt to respond to these identified inadequacies in the nursing literature.

Between September 1982 and September 1984, combining theory from the literature on planned change with an analytical design based on program evaluation and using a variety of sampling plans, the investigator collected data from 28 informants who had become involved in the change process. The data from 60 interviews, documents on the unit which covered a three year period, and field notes generated by the investigator over a two year period were analyzed using qualitative techniques.

A description of what happened from the perspectives of four teaching nurses (staff nurses who had volunteered to teach the program), three head nurses, one director of nursing services, one area supervisor, and one physiotherapist and an analysis of the findings were presented in Chapters 4 through 8. In addition, based on the evidence of data presented in these five chapters, tentative 'stage-specific' conclusions and hypotheses were generated. In Chapter 9, the reactions of the staff nurses (who did not join the teaching team), the doctors, and the patients to the change process were reported and analyzed.

This final chapter is comprised of three sections. In the first section, concluding statements are made about the change process which evolved over the two year period. In the second section recommendations are presented. Finally, reflections of the investigator about the approach to and the process of conducting the study are presented.

## Conclusions Specific to the Study Questions

Seven questions guided the study as the investigator sought to discover what happened when the nurses on unit Y in hospital X attempted to develop and implement a teaching program for patients with a chronic illness. The questions were:

1. Through what stages did the change progress and what was the change process like?

2. What were the characteristics of the change?
3. What strategies of change were utilized?
4. What factors facilitated or inhibited the process of change?
5. What were the characteristics and influence of individual roles on the change?
6. What was the influence of antecedent conditions on the change?
7. What were the outcomes of the change?

During analysis of the data, questions 2, 3, 5, and 6 were subsumed by questions 1, 4, and 7 with the result that the seven questions originally generated to examine the change process could be collapsed into three:

1. Through what stages did the change progress and what was the process like?
2. What factors influenced the change process?
3. What were the outcomes of the change?

The conclusions about the three questions are presented and discussed in the following section.

## Question 1: Through What Stages Did the Change Progress and What Was the Process Like?

The evidence indicated that change is a process, not an event. In the present study, the change process was comprised of four stages. The four stages, illustrated in Figure 10.1(a), were initiation/adoption, implementation of the first program five times (the Trial Run), planning and development, and implementation of the planned program. The stages appear similar to those generated by Fullan [Figure 10.1(b)], after he had completed a macroanalysis of the

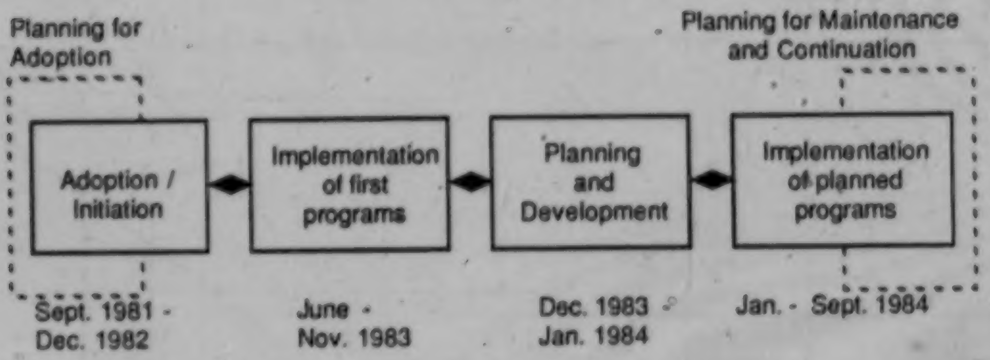
Planning for Adoption
Planning for Maintenance and Continuation
Adoption / Initiation
Implementation of first programs
Planning and Development
Implementation of planned programs
Sept. 1981 - Dec. 1982
June - Nov. 1983
Dec. 1983 - Jan. 1984
Jan. - Sept. 1984

Figure 10.1 (a)
The Stages of the Change Process Which Evolved
In the Present Study

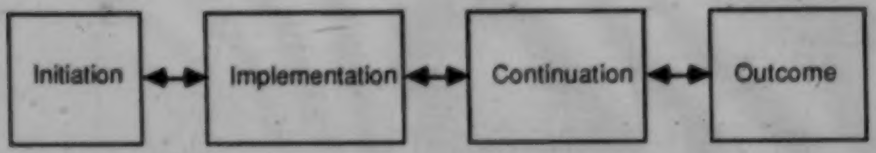
Initiation
Implementation
Continuation
Outcome

Figure 10.1 (b)
A Simplified Overview of the Change Process

Reproduced from The Meaning of Educational Change
by Michael Fullan; co-published by OISE Press, 1982.

**Figure 10.1**

A Comparison of the Stages of the Change Process Which Evolved
in the Present Study with the Stages Which Emerged
in Fullan's Work

relevant literature on change, in educational settings. Concluding statements are made about each stage based on the findings and discussions presented in Chapters 4 through 8.

The adoption stage. Eight conclusions were drawn in relation to the stage of adoption:

1. The time period from inception of a plan to develop and implement an education program for patients with a chronic illness to adoption of the proposal for that program was approximately 16 months.
2. Planning occurred in the period prior to adoption.
3. The idea to develop and implement a teaching program was accepted by the first head nurse, one physiotherapist, one doctor, the director of nursing service, and the volunteer Association.
4. Planning to secure adoption and adoption activities were mainly instigated and conducted at the unit level primarily by the unit leader, the first head nurse.
5. The staff nurses, including the would-be teaching nurses, supported the proposal to implement the program.
6. The staff nurses were not involved in and knew very little about the negotiations involved in the adoption stage.
7. The area supervisor was not involved in planning for adoption. Due to the reporting structure which was established, the first head nurse communicated directly with the director of nursing services.
8. The chief executive nursing officer intervened during the

adoption stage to take over communication external to the unit about project funding, thus removing from the head nurse the ability to monitor funding activities.

Implementing the first program (the Trial Run). Sixteen concluding statements can be made about implementation of the first program five times:

1. Five months elapsed between adoption and implementation.
2. Inadequate planning for implementation activities was conducted during the five months between adoption and implementation.
3. Prior to implementation, the teaching nurses identified concerns about the meaning of their involvement in the change and about the goals and means of implementation.
4. Inadequate actions were taken or plans made prior to implementation to address the concerns of the teaching nurses.
5. The philosophy, goals and objectives of the program were not clarified prior to implementaton.
6. Lecture content was not developed prior to implementation; rather, the nurses delivered the program five times during the six months, teaching classes from material prepared for the old program by one physiotherapist.
7. Expected learner outcomes were not identified prior to implementation.
8. Plans for patient follow-up and program evaluation, other than the present study, were not identified prior to implementation.
9. Learner outcomes were observed and reported by the teaching nurses early in the implementation stage.

10. Areas of the program which required revision, additions, deletions and refocussing were identified by the teaching nurses early in the implementation stage.
11. The first head nurse thought that implementation of the first program would be a trial run, while the teaching nurses considered implementation to be the real thing. This led to five repetitions of the program in its trial form before major content revisions were made.
12. The teaching nurses communicated infrequently with each other about the program prior to or during implementation.
13. The unit was leaderless during implementation of four of the first five programs. The first head nurse resigned and a staff nurse was appointed to fill the position of acting head nurse.
14. Although training sessions for the nurses were conducted by the physiotherapy department, who had previously delivered the program, no nurse attended all the sessions.
15. The work technology of the unit interfered with implementation of the program.
16. Implementation had to be stopped after six months to allow the teaching nurses to plan and develop the program. The lecture content, the record keeping systems, the patient assessment tools, and the philosophy, goals and objectives of the program had not been developed prior to the Trial Run.

Planning and development. Eight concluding statement can be made about the planning and development period which occurred during December 1983 and January 1984.

1. The teaching team was leaderless during the planning and development period.
2. Members of the teaching team had little knowledge about, few skills, and no previous experience with planning and development activities in general and with the process of developing a teaching program in particular.
3. Planning and development activities were not a priority for all of the teaching nurses.
4. The work technology of the unit interfered with planning and development activities.
5. The nurses rarely communicated with each other as a group during planning and development.
6. Planning and development activities were positively influenced by implementation activities; in particular, the fact that the nurses had taught the program five times.
7. Planning and development activities were more complex and took much longer to complete than was anticipated.
8. Plans for refocussing were made during the planning and development period.

_Implementation of the planned program_. Five concluding statements can be made about the stage of implementation of the planned program.

1. The unit remained leaderless during implementation of the planned program.
2. Motivation of the original teaching nurses decreased during implementation of the planned program.
3. Plans made during the planning and development stage were not

implemented during this stage.

4. Plans for maintenance and continuation were made during this stage by the unit leader and area supervisor.
5. Implementation was revitalized by the plans for maintenance and continuation; particularly by the addition of two new teaching nurses and a second program coordinator and by the provision for feedback to the staff nurses about the program.

An overview of the change process. In the preceding section, concluding statements have been made about each specific stage of the change process. Five concluding statements can be made about the process as a whole which was illustrated in Figure 10.1(a).

1. Change is a process comprised of numerous stages.
2. Although separate stages in the change process can be distinguished, the stages of change are not discrete and are not mutually exclusive. On the contrary, the stages are highly interrelated. What happens in one stage has a profound impact on what happens in following stages; in fact one can say that the events of one stage become the antecedent conditions for the next stage. Although the progression from stage to stage may on first observation appear to be linear, the process is contorted, involving many feedback loops or perhaps spirals which wind their way forewards and backwards through each stage and through the process as a whole.
3. It is necessary that planning activities be conducted prior to each stage. One can say that a planning period becomes a necessary transition stage between each stage, beginning before

the first stage is completed and continuing on into the second stage and so on throughout each stage of the change process.

4. Evidence of learner and participant outcomes can be observed very early in the change process. Although a summative assessment of change effectiveness should be reserved until the change has reached the level of routinization, formative assessment does occur and should be planned and conducted throughout each stage of the change process.

5. The change process takes on a life of its own and the process is, itself, ever changing. Rather than striving for a state of maintenance or stabilization the process may involve an ongoing repeated 'cycling of the stages' phenomenon resembling Figure 10.2. If this is the case, the following would happen: a) plans are made for initiation/adoption; b) adoption of the program is approved; c) plans are made for development; d) development activities are conducted; e) plans are made for pilot implementation; f) pilot program is implemented; g) pilot implementation is evaluated/assessed; h) plans are made for revised implementation; i) revised plans are implemented; j) revised implementation is evaluated/assessed; k) plans are made for revitalized/refocussed implementation; l) revitalized program is implemented; m) revitalized program is evaluated and assessed; n) implementation continues. If the change process involves the above cycling phenomenon, then it seems to be a frustrating kind of experience to expect that the change process has a beginning and an end, that is to think that

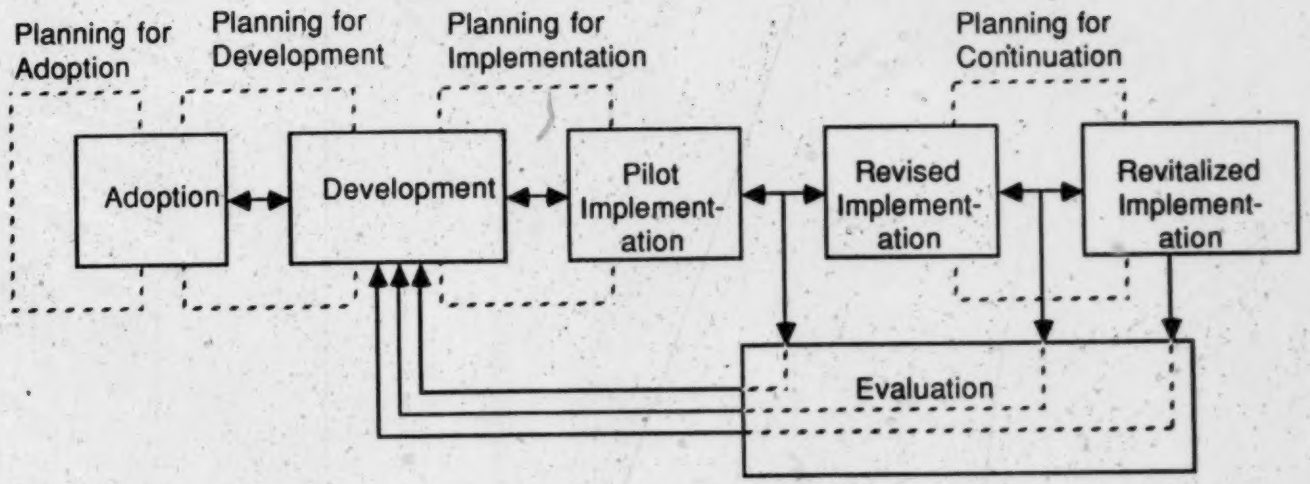
Planning for Adoption
Planning for Development
Planning for Implementation
Planning for Continuation
Adoption
Development
Pilot Implementation
Revised Implementation
Revitalized Implementation
Evaluation

**Figure 10.2**

Overview of the Process of Change

change begins with initiation and ends with stabilization. It would perhaps be more useful and less frustrating to those involved in planning and implementing the change to think of the change process as ever changing and as involving ongoing periods of planning, development, implementation, assessment, revision, and revitalization.

## Question 2: What Factors Influenced the Change Process?

During the discussion section of Chapters 4 through 8, factors were identified that had either facilitated or inhibited the process of the particular stage of change being examined. After two years of data collection and analysis, a composite picture of the factors which influenced the change process emerged. The factors are listed in Table 10.1. Seven concluding statements, based on an examination of Table 10.1 can be made about the factors which influenced the process of change in the present study:

1. Fourteen blocks of factors influenced the stages of change process.
2. Each block of factors could be 'unpacked' to reveal numerous sub-factors or variables, 40 in total.
3. Some factors (e.g., 3.1 administration and 4.2 time, money and typing services) had both a positive and a negative influence on the process depending on the particular stage of the process.
4. Some factors had an influence only on specific stages of the process (e.g., 3.5 support of the doctors, and 4.1 availability of external funds).

## Table 10.1

### Factors Which Influenced the Process of Change

| Factors | Adoption | Implementation of the First Programs | Planning and Development | Implementation of the Planned Programs |
|---|---|---|---|---|
| 1. Need for the change | | | | |
| 1.1 recognize a need | + | + | + | + |
| 1.2 observe outcomes | + | + | + | + |
| 2. Leadership | | | | |
| 2.1 at unit level | + | - | - | + |
| 2.2 at program level | N/A | + | - | - |
| 3. Support of others/ recognition | | | | |
| 3.1 administration | + | - | + | - |
| 3.2 community | + | | | |
| 3.3 other departments within organization | + | - | - | - |
| 3.4 support of staff nurses | + | neutral | - | + |
| 3.5 support of doctors | + | neutral | + | neutral |
| 4. Resources | | | | |
| 4.1 external funds | + | | | + |
| 4.2 time, money, and quality typing services within organization | N/A | N/A | ± | - |
| 4.3 expert consultants | N/A | N/A | + | N/A |
| 4.4 existing models of similar program | N/A | + | +<br>- | N/A |
| 5. Antecedent conditions | | | | |
| 5.1 development of old program by one physiotherapist | - | - | - | - |
| 5.2 conflict | - | - | - | - |
| 5.3 power and authority at program level | N/A | - | - | - |

Table 10.1 (continued)

| Factors | Adoption | Implementation of the First Programs | Planning and Development | Implementation of the Planned Programs |
|---|---|---|---|---|
| 6. Clarity | | | | |
| 6.1 identification of goals, objectives and means | - | - | - | |
| 7. Complexity | | | | |
| 7.1 technology of work at unit level | - | - | - | - |
| 7.2 technology of work at program level | N/A | - | - | - |
| 7.3 reporting structure | - | - | - | - |
| 7.4 opportunity to engage in reflective conversation | - | - | - | - |
| 8. Multiple realities | | | | |
| 8.1 needs, roles, expectations | - | - | - | - |
| 8.2 commitment, motivation | + | + | + | - |
| 9. Staff development | | | | |
| 9.1 availability and quality | - | + | - | - |
| 9.2 participation | - | - | - | - |
| 10. Planning for each stage | | | | |
| 10.1 adoption | + | | | |
| 10.2 implementation | | - | | |
| 10.3 planning and development | | | - | |
| 10.4 maintenance/continuation | | | | + |
| 11. Knowledge of and experience with the process of the stage | | | | |
| 11.1 adoption | - | | | |
| 11.2 implementaion | | - | + | + |
| 11.3 planning and development | | | - | |
| 12. Materials production | | | | |
| 12.1 availability of materials | - | - | + | - |
| 12.2 quality of production | N/A | N/A | - | - |
| 12.3 characteristics of materials produced | N/A | N/A | - | - |

Table 10.1 (continued)

| Factors | Adoption | Implementation of the First Programs | Planning and Development | Implementation of the Planned Programs |
|---|---|---|---|---|
| 13. Information systems | | | | |
| 13.1 record keeping at program level | N/A | - | + | - |
| 13.2 documentation about program at unit level | - | - | - | - |
| 13.3 patient follow-up | - | - | - | - |
| 13.4 program evaluation | - | - | - | - |
| 14. Domain of the discipline | | | | |
| 14.1 meaning of the domain of nursing | + | - | - | - |

| | |
|---|---|
| + | indicates the factor had a facilitative or positive influence on the indicated stage of the change process. Total = 37. |
| - | indicates the factor had an inhibiting or negative influence on the indicated stage of the change process. Total = 82. |
| N/A | factor not evident at this stage. |
| neutral | indicates factor had either a neutral effect or no effect on the indicated stage of the change process. |

5. Some factors (e.g., 4.3 expert consultants and 12.2 quality of materials production) did not have an influence until the change process was well under way; suggesting that new factors which influence the change continue to emerge as the change progresses (Hall and Loucks, 1982).
6. Some factors (e.g., 2. leadership and 7. complexity) had an impact on the process at both the unit level and the program level.
7. In total, the factors produced 37 positive influences and 82 negative influences on the process.

In addition to the general conclusions stated above, a brief concluding statement can be made about each of the 14 factors which were determined to have influenced the process of change in this study.

Need for the change. The fact that most of the participants (excluding perhaps one physiotherapist) recognized and believed in the need for the change had a positive influence on the change process (Table 10.1, #1). This was the only factor to have had a consistently positive effect on every stage of the process and must be judged to have had the most profound facilitating effect on the process. Furthermore, the need for the change was consistently reinforced when the participants in the change, in particular the teaching nurses, continued to observe behavior changes in the patients and in themselves which could be attributed to the program.

Leadership. The influence of leadership on the change process was apparent throughout all stages of the process (Table 10.1, #2). First, the leadership was inconsistent and unstable. Three levels of leadership had an influence on the process. At the unit level, three different nurses held the position of head nurse at various times. While all three unit leaders indicated that they supported the change, the fact that the leadership was unstable after the adoption stage, had a detrimental effect on the change process. At the program level, while the program coordinator was extremely committed to the program and produced a substantial amount of quality work, it became apparent to herself and others that she did not possess the knowledge, skills or experience required to assume a leadership role in the process. Leadership on the part of the area supervisor was somewhat lacking and inconsistent throughout all stages of the process.

Second, no formal leader acted as facilitator, coach or mentor to the teaching nurses during the entire change process. The teaching nurses, on the whole, were left to "flounder on their own." This lack of formal and stable leadership during the stages of the change had a profound inhibiting effect on the process.

Support of 'others.' The support of 'others,' particularly nursing administration, the rehabilitation department, the staff nurses and the doctors had a facilitating effect on the stage of adoption (Table 10.1, #3). However, this support was inconsistent as the change progressed through the remaining stages. When nursing administration and the doctors did offer advice, bestow recognition, and/or provide resources, the influence on the process was profoundly facilitative. On the other hand, when nursing administration and the doctors took no action or remained neutral, this was interpreted by the teaching nurses as disinterest, lack of caring, and non-support which had a profoundly inhibiting influence on the process. According to the evidence in this study, everything that the rehabilitation department did, in particular one physiotherapist, was interpreted by the teaching nurses as negative. On the whole, support of the 'others' during the change could have been more positive, more consistent, and more evident during the process.

Resources. The influence of resources on the process of change was inconsistent (Table 10.1, #4). First, assurance of funding by the external volunteer Association had a facilitating influence on the stages of adoption and implementation of the planned program. In fact, it is highly questionable whether the decision to implement the program would have been approved had external funding not been provided. However, the problems of transferring funds between the Association and the hospital, and a lack of documentation related to prior agreements between the Association and the former head nurse and between the program coordinator and the Association had an inhibiting effect on the motivation of the teaching nurses in particular and on the process in general. Second, while the hospital at times did provide time for planning, money, and typing resources, the time was not predictable, adequate or soon enough; the money was not predictable and adequate; and the typing services were not fast enough or of a quality required by the teaching nurses. Third, while experts in program planning were apparently available in the hospital, they did not begin consulting with the teaching nurses soon enough, did not provide consistent consultation to all the teaching nurses, and did not provide consultation appropriate to the needs of the teaching nurses. Fourth, while models of teaching programs did exist in the hospital, the teaching nurses were not made aware of their existence until six months after implementation was begun. On the whole, a lack of predictable, sufficient, consistent, and high quality resources inhibited the process of change.

Antecedent conditions. The existence of antecedent conditions had a profound inhibiting effect on the process of change (Table 10.1, #5). First, the fact that one physiotherapist had developed the original teaching program inhibited development and implementation of what the nurses thought was a new program. Second, conflict between individuals, among groups of individuals, and between departments about such issues as control over patient selection, ownership of the program, authority, power, roles, professionalism, status, and educational requirements had existed long before the program was adopted. On listening to the participants describe the emerging and pre-existing problems, the investigator began to envision the existence of a 'battle zone' of conflict which is illustrated in Figure 10.3. As depicted in Figure 10.3, the head nurses, the teaching nurses, the physiotherapy department, the doctors, and the program coordinator were in the midst of the conflict, while the area supervisor, the director of nursing service, the chief executive nursing officer, the hospital finance department, the Association, the patients, and the staff nurses appeared to be on the outer fringes of the conflict. In other words, those participants most actively involved with implementing the change, except for the doctors, were the ones most often involved in conflict and were most affected by the

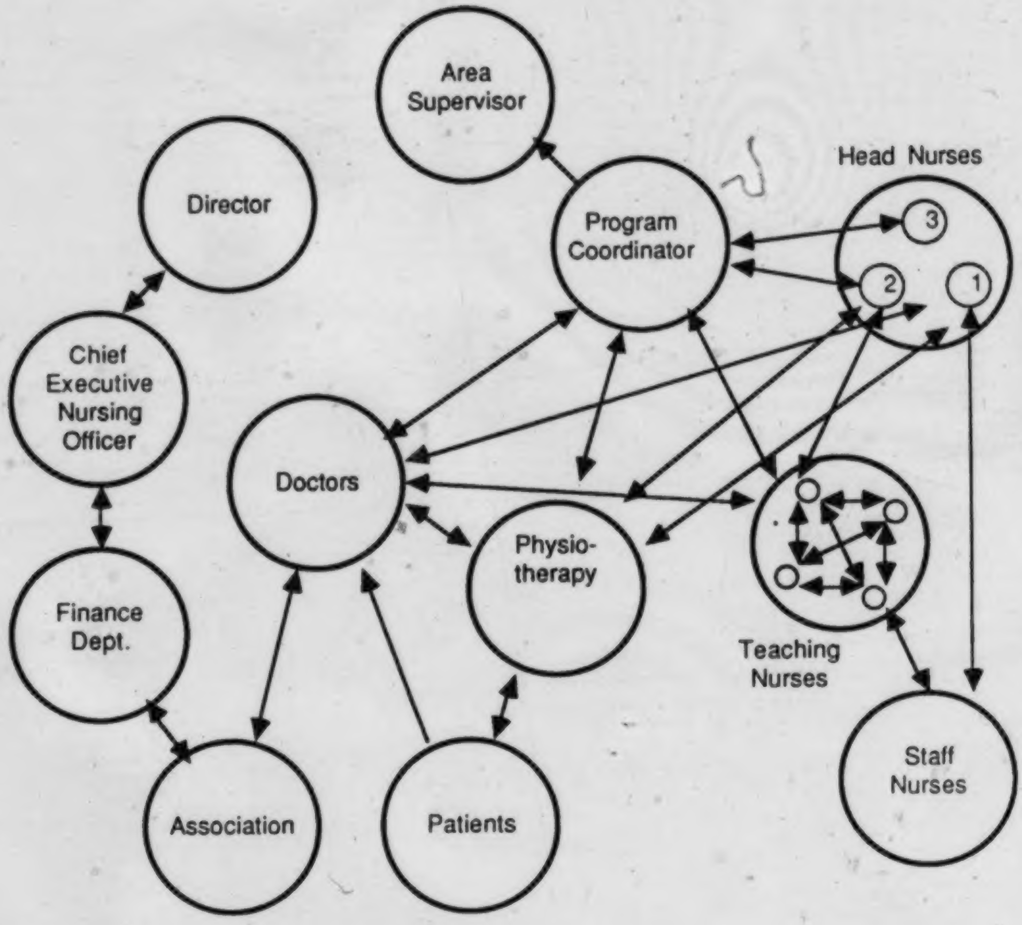
Area Supervisor
Director
Head Nurses
Program Coordinator
3
2
1
Chief Executive Nursing Officer
Doctors
Physio-therapy
Teaching Nurses
Finance Dept.
Staff Nurses
Association
Patients

**Figure 10.3**

Conflict Configurations as Reported by the Participants
During the Process of Change
in the Present Study

antecedent conditions. Those participants least involved in implementation, except for the patients, were the least affected by conflict and antecedent conditions.

Clarity. The change process in the present study lacked clarity (Table 10.1, #6). The teaching nurses were unsure about the goals, the expected learner outcomes and the means of implementation. In retrospect, it became evident that they knew little about the stage of adoption. Although the nurses identified their initial concerns during the first three meetings with the investigator and made their concerns clear to the first head nurse, the program was delivered five times over a period of six months with little clarification of the identified concerns. Finally, in December of 1983, implementation was suspended until planning and development activities related to the program could be undertaken. Even during development and implementation, the goals and the means for implementation of the activities in this stage remained unclear. Overall, the lack of clarity had a profound inhibiting influence on the process of change.

Complexity. Planning, development, and implementation of the change was a complex endeavour, and this complexity had a profound inhibiting effect on the change process. Table 10.1, #7 indicates that all the variables of this factor had a negative influence on the process. The work technology at the unit level was complex. The work environment was unpredictable and interrupted. 'Off-service' and emergency patients were admitted to the unit. Teaching nurses were not consistently assigned to nurse the teaching patients. Rotation patterns were not congruent with teaching schedules, in-service presentation schedules or staff meeting schedules. This conclusion is particularly noteworthy when one remembers that unit Y was considered by nursing administration to be one of the more stable and least complex units in the hospital.

The work technology of the program was also complex. Time in which to conduct planning activities was unpredictable and interrupted. Planning, writing and 'brainstorming' took longer and was much more difficult than expected in the view of administration and the nurses themselves. Nurses with different levels of educational preparation attempted to complete tasks (e.g., writing objectives) for which they were not prepared and/or with which they had no experience. Rotation schedules of the teaching nurses were not congruent with training session schedules, group meeting schedules, lecture schedules, rehabilitation department schedules, and the doctor's schedules. The reporting mechanism which had been established during the adoption stage did not allow the area supervisor to keep informed about the progress of the program and did not allow the program coordinator to go beyond the unit boundaries for assistance. The teaching nurses rarely met as a group to engage in reflective conversation and so failed to become aware of the other's view of the meaning of this change. The program had in fact taken on a 'life' or work technology of its own within the work technology of the unit and the two were simply not compatible. Planning, development, and implementation within this environment turned out to be much more complex and to take much longer than any of the participants during the adoption stage, had ever anticipated. This complexity had an overall inhibiting effect on the change process.

Multiple realities. The existence of multiple realities had an inhibiting influence on the process of change (Table 10.1, #8). Each participant functioned in relation to her own needs, expectations, roles, and reward systems. Each participant had her own view of the priority of this program in relation to the overall functioning of the unit. Each participant had her own level of and reason for commitment to the program. However, the participants rarely talked to each other about the program. The result was that a mulititude of realities existed in isolation and the mere existence of these realities had an overall detrimental effect on the process of change.

Staff development. The lack of consistently available quality staff development activities had an inhibiting influence on the change process (Table 10.1, #9). In addition, the teaching and staff nurses were reluctant to attend the development sessions that were made available.

Planning. A lack of planning for each stage of the change process had a profound inhibiting influence on the process of change (Table 10.1, #10). The nurses were not actively involved in planning for adoption of the program. Minimal planning was done for implementation in spite of the fact that the nurses, prior to implementation, identified the need to develop content, to practice group teaching, to identify learner needs, to design evaluation tools, and to design record keeping systems.

The program coordinator made plans for the development period. The other three teaching nurses indicated either that they were not made aware of the plans or that they had developed their own agendas by which they planned to function during the development period.

The new head nurse and the area supervisor did begin to plan for maintenance and continuation of the program. The data collection period was completed before it could be determined if the plans were followed through. On the whole, plans were not made for each stage and the few that were made were not communicated among the nurses and were not acted upon.

Knowledge and experience. A lack of knowledge about and experience with the process of each stage on the part of the participants inhibited the change process (Table 10.1, #11). The nurses had little knowledge of the skills required to adopt, plan and implement the change. None of the nurses had been previously involved in mounting a teaching program. They simply did not know what to do or how to do it. Of note however, was the opinion of the nurses that it was easier to develop a teaching module after having been forced to teach the classes than it would have been to develop the module without having tried to teach a class.

Materials production. A lack of available teaching materials and facilities for production early in the change process inhibited the change process (Table 10.1, #2). The teaching nurses did not see the materials, which had been produced previously by the physiotherapist, prior to teaching their first program. When the nurses did engage in development activities, they considered the quality of their product to be superficial and mediocre.

Information systems. A lack of knowledge about what information to collect and how to collect it inhibited the process of change (Table 10.1, #13). Documentation about the adoption stage was inadequate and later led to problems between unit Y and the funding agency. Record keeping during implementation of the first five programs was inadequate and inconsistent. While the nurses identified this as a problem area, they had neither the time, nor did they know how to solve the problem until well into the development stage. Even then, they encountered difficulties trying to implement the plans they had developed. During the entire study, patient follow-up and program evaluation activities were almost non-existent. While the nurses did engage in revision and refocussing activities during the planning and development stage, they did not view these activities to be of an evaluative nature. They had not gone about collecting data, nor did they know how or what data to collect, in a systematic fashion which they considered would be part of evaluation and follow-up activities.

Domain of the discipline (nursing). The final factor which appeared to influence the change process was related to the domain of the discipline (Table 10.1, #14). A lack of clarity of what constituted the domain of nursing existed. The nurses did not know how to identify the content which should be included in a nursing class. They had difficulty differentiating between nursing content and medical content.

The nurses had difficulty identifying what constituted the nurses' role as opposed to the doctors' role and the physiotherapists' role in patient care and in this particular teaching program. They were reluctant to leave the bedside and chose to do either 'hands-on' patient care or program related activities. It seemed that the nurses could not integrate patient teaching and program related activities into their overall concept of nursing. They did not like to leave the unit to attend a class because they were afraid it would leave their colleagues short-handed on the unit even when the unit was not busy.

The nurses appeared to require structure and guidance in their daily work on the unit. They had difficulty setting their own goals, being self directed, gaining or using power, and taking action to identify how much authority they really had. It appeared that the nurses reacted rather than pro-acted to situations around them.

The teaching nurses appeared to need to 'travel in a pack'. Working in an office, working in street clothes, working staggered hours, working at home and leaving the unit on their own for coffee or lunch caused them to feel uncomfortable and guilty and caused at least one staff nurse to question their productivity. On the whole, this uncertainty about what constituted the domain of nursing and what was the subsequent role of the teaching nurse and staff nurse in the teaching program inhibited the process of change.

Relationship between and among the factors. There is a tendency to think of the 14 blocks of factors as being discrete, each having an influence on the change process, as is illustrated in Figure 10.4. The fourteen blocks of factors previously discussed, did have an influence on the process. However, as with the stages of implementation, the influence of the factors was not discrete, but was interrelated. Using a blocking technique developed by Blalock (1966), the factor or variable relationships are illustrated in Figure 10.5.

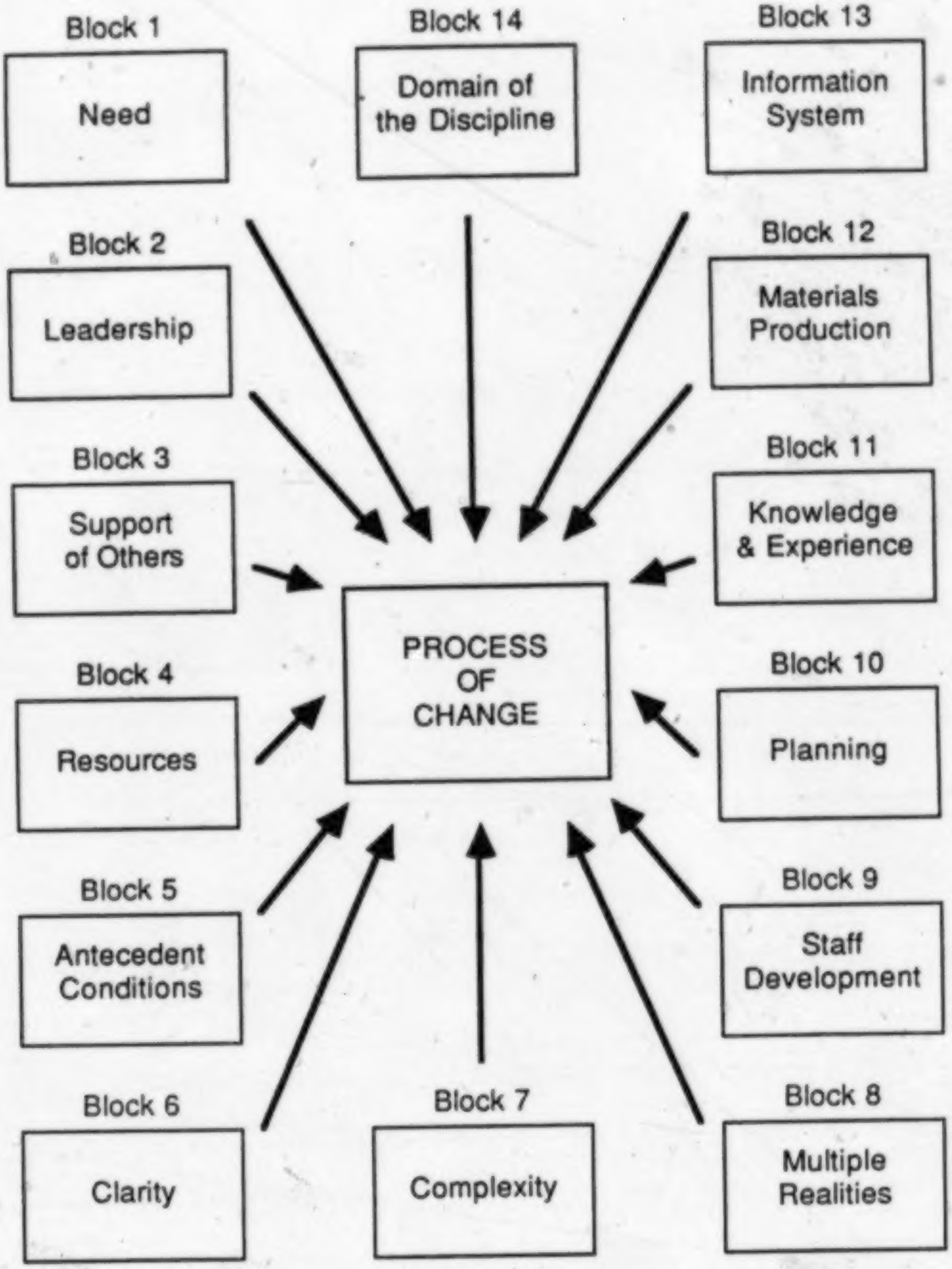
Block 1
Need
Block 14
Domain of the Discipline
Block 13
Information System
Block 2
Leadership
Block 12
Materials Production
Block 3
Support of Others
Block 11
Knowledge & Experience
PROCESS OF CHANGE
Block 4
Resources
Block 10
Planning
Block 5
Antecedent Conditions
Block 9
Staff Development
Block 6
Clarity
Block 7
Complexity
Block 8
Multiple Realities

**Figure 10.4**

Blocks of Factors Which Influenced the Process of Change in the Present Study

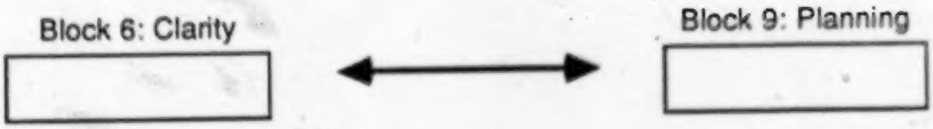
Block 6: Clarity
Block 9: Planning

**Figure 10.5 (a)**

Inter-block Relationship of Factors Which Influenced the Change Process

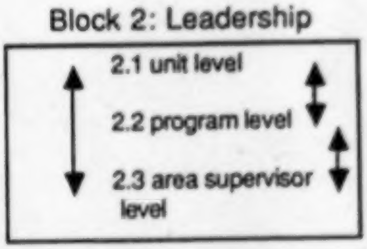
Block 2: Leadership
2.1 unit level
2.2 program level
2.3 area supervisor level

**Figure 10.5 (b)**

Intra-block Relationships of Factors Which Influenced the Change Process

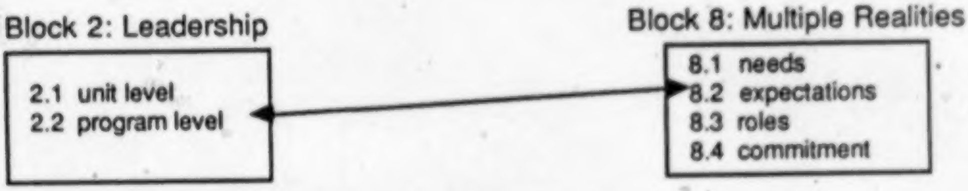
Block 2: Leadership
2.1 unit level
2.2 program level
Block 8: Multiple Realities
8.1 needs
8.2 expectations
8.3 roles
8.4 commitment

**Figure 10.5 (c)**

Intra-block to Intra-block Relationships of Factors
Which Influenced the Change Process

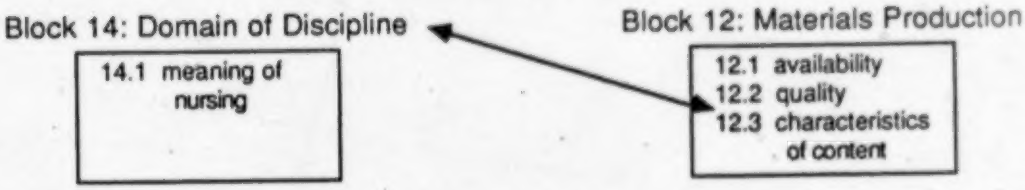
Block 14: Domain of Discipline
14.1 meaning of nursing
Block 12: Materials Production
12.1 availability
12.2 quality
12.3 characteristics of content

**Figure 10.5 (d)**

Block to Intra-block Relationships of Factors
Which Influenced the Change Process

**Figure 10.5**

Types of Relationships Which Influenced the Change Process
in the Present Study
Conceptual Source: Blalock,1966.

Parts (a) to (d) in Figure 10.5 to point out that the influence of each block of factors on the change process and the interrelationships between the blocks and the factors or variables was extremely complex.

Figure 10.5(a) indicates that a relationship existed between blocks of factors. For example a lack of clarity (Block:6) about the goals and means of implementation at each stage in the process seemed to have a negative influence on planning for each stage (Block:9). The combined result appears to have been an inhibiting influence on the change process.

Figure 10.5(b) indicates that intra-block relationships occurred between the factors. For example, it seems that in the block of factors concerned with leadership (Block:2), a lack of leadership at the unit level had an influence on leadership at the program level resulting in an overall inhibiting effect on the change process.

Figure 10.5(c) indicates that a relationship existed between the factors within different blocks. For example, a lack of leadership at the program level (one factor in Block 2: Leadership) appears to have influenced the expectations of each individual involved in the change and vice versa (one factor in Block 8: Multiple realities). The overall impact of this relationship was to inhibit the change process.

Finally, as illustrated in Figure 10.5(d) there existed Block-to-intra-block relationships. For example, a lack of clarity about the domain of nursing (Block 14) appears to have influenced the kinds of materials which were produced; in particular, the characteristics of the content of the modules (Block: 12, #12.3). Overall, the interrelationship of these two factors appears to have inhibited the change process.

In summary, 17 concluding statements can be made about the factors which influenced the change process.

1. A multitude of variables facilitated and inhibited the change process.
2. Rather than change being a convergent process with the number of variables and the complexity of variable relationships decreasing and narrowing as the change progresses, change turns out to be a divergent process with the number of variables and the complexity of variable relationships increasing as the change process unfolds.
3. The meaning of the change is unique for each individual involved and for each level of the organization.
4. Successful implementation of each stage of the process is related to the knowledge and experience which the implementers have with the previous stage.
5. Successful implementation of each stage is related to the quality of planning prior to implementation of the stage.
6. Successful implementation of change is related to a recognition of the need for the change and a belief in the need for the change by those actively involved in implementation.
7. Successful implementation of the change is related to consistent, knowledgeable, skilled and experienced leadership at the program, the unit, the area supervision, and the senior administration level.
8. Successful implementation of change is related to the active

and visible support of other departments participating in the change, area and senior administration, and external funding agencies.

9. Successful implementation of change is related to the availability, predictability and quality of resources, including time, internal funding, internal services, and expert consultants.
10. Successful implementation of change is related to a recognition of and an understanding of antecedent conditions by the implementers which exist prior to adoption.
11. Successful implementation of change is related to the clarity, that is the goals and means, of the change.
12. Successful implementation of change is related to a recognition of and an understanding of the complexity of the process of change and the process of each stage of the change by the participants, in particular, the work technology of the unit and the evolving work technology of the program being implemented.
13. Successful implementation of change is related to the amount of and depth of understanding by each participant of the others' meaning or reality of the change.
14. Successful implementation of change is related to consistently available staff development activities of a high quality and to the amount of participation in those activities by the implementers.
15. Successful implementation of change is related to the

availability to the implementers of quality models or materials of a similar nature as the program is being implemented.

16. Successful implementation of change is related to knowledge and experience of the implementers with developing and using information systems; in particular, systems for record-keeping, learner assessment, learner follow-up, and program evaluation.

17. Successful implementation of change is related to the clarity of understanding by the implementers about the domain of the discipline involved in the change; which in the present study were the domains of nursing and of teaching.

In conclusion, numerous factors, acting in a variety of configurations had a profound impact on the process of change. The process, as Fullan (1982:40) had warned, when he presented a simplified overview [Figure 10.1(b)] of the process of change, was indeed snarled and detailed:

> [Figure 10.1(b)] presents only the general image of a much more detailed and snarled process. First, there are numerous factors operating at each phase. Second, as the two-way arrows imply, it is not a linear process but rather one in which events at one phase can feed back to alter decisions taken at previous stages, which then proceed to work their way through in a continuous interactive way . . . The third set of variables specified in [Figure 10.1(b)] concern the scope of change and the question of who develops and initiates the change . . . The fourth complication in [Figure 10.1(b)] is that the total time perspective as well as subphases cannot be precisely demarcated.

Throughout this report, the factors which evolved in the present study have been compared with those generated by Fullan in 1982. A large degree of congruence between the two sets of factors is evident.

The factors also appear to be congruent with those identified in other studies on the process of change, particularly in educational settings. Studies conducted by Charters and Pellegrin (1972), Simms (1978), Miles (1979), and Levin (1981) were discussed in Chapter 1. Factors which had influenced the process of change were identified in each of those studies.

When a comparison is made between the 14 blocks of factors (including the 40 variables which can be 'unpacked' from the blocks) that were generated in the present study and the factors identified in the above studies, a large degree of congruence again becomes evident. Thus, the findings in this study would seem to be congruent with findings of previous research related to change.

In addition, four new factors emerged which appear to extend the current research. These were: (1) effects on the implementers of observing learner outcomes, (2) influence of the work technology of the unit on implementation and influence of the emergent work technology of the change itself on implementation, (3) effect of an understanding or lack of understanding about the domain of the discipline on implementation, and (4) effect of antecedent conditions on the process of change. These appear to be important factors which should be examined in future studies on the process of change.

### Question 3: What Were the Outcomes of the Change?

Although the process was detailed and snarled and in the opinion of the teaching nurses was frustrating and difficult to manage, some outcomes did emerge during the 16 months of implementation. The outcomes are to be viewed with caution, and are intended to be seen as only preliminary or formative outcomes, for as Hall and Loucks (1977) caution, evaluation should not be conducted until the innovation has reached the level of routine use.

Formative outcomes were evident for the teaching nurses, the doctors, the staff nurses, and the patients and were discussed in Chapter 9. Concluding statements can be made about these outcomes.

Outcomes for the teaching nurses. Four concluding statements can be made about the involvement of the teaching nurses in the change process.

1. The teaching nurses were forced to learn new knowledge about the chronic disease.
2. The anxiety level of the teaching nurses decreased as their experience teaching the program increased.
3. The motivation of the teaching nurses to teach the program decreased as their frustrations with implementation increased.
4. The different educational levels of the nurses did inhibit the development of selected sections of the program and gave those nurses with diploma education a reason to reconsider their decision not to pursue baccalaureate education.

Outcomes for the doctors. Five concluding statements can be made about the involvement of the doctors in the change process.

1. The doctors were interested in and committed to the implementation of the program.
2. The doctors were not directly involved in planning or delivering the program.

3. The doctors did advertise the program throughout the province, the country and abroad.
4. The doctors considered themselves, particularly the chief staff man, to have overall authority for the program, rather than any one of the other involved disciplines.
5. The doctors did not have a greater amount of interaction with the staff nurses during implementation of the program than they had before implementation of the program.

Outcomes for the staff nurses. Three concluding statements can be made about the involvement of the staff nurses in the change process.

1. Some of the staff nurses were forced to learn new knowledge about the chronic disease.
2. The staff nurses inadvertently became involved in patient teaching on a one-to-one basis during implementation.
3. The staff nurses who were most recently hired to work on the unit and who had the least nursing experience appeared to be the most interested in becoming involved in program activities.

Outcomes for the patients. Five concluding statements can be made about the outcomes of the program delivery for the patients.

1. The patients thought the program was worthwhile and needed.
2. The patients acted as program advocates, informing others of its existence and recommending that others take the program.
3. The patients insisted that all patients with the chronic disease should be monitored by a specialist.
4. The patients felt the group experience was the most beneficial part of the program. The patients bonded with other patients in

the group, feeling that other patients were the only people who understood the pain, fatigue and depression that was associated with the disease.

5. The patients made attempts to comply with exercise and rest regimens, to comply with medication routines, and to avoid the temptations of 'a cure' offered by family, friends, and peddlars of quackery.
6. The patients considered the out-patients clinic to be impersonal and inefficient. They developed creative strategies to avoid becoming dependent on the clinic for on-going monitoring of their disease.
7. The one out-patient did not appear to have benefitted from the program as much as had the in-patients.

In summary, it can be said that implementation of the program was a success. In terms of outcomes, the patients, the teaching nurses, and the staff nurses benefitted from their involvement in the program.

The cost of achieving successful outcomes, however, was great to the implementers of the change. Areas of conflict had existed prior to program adoption and continued to become evident during implementation. The teaching nurses cycled through periods of enthusiasm and depression, confidence and insecurity, satisfaction and dissatisfaction, love and hate relationships, and motivation and frustration. The process of change was unclear, more complex and took much longer than the participants ever anticipated. At the conclusion of the data collection period, the frustration with the process of the change had taken its toll on the teaching nurses. Of the four original teaching nurses, one had left unit Y and two were planning to leave. However, it appeared that the new head nurse and senior nursing administration had observed and recognized some of the problem areas, for plans were made for continuation, plans which appeared to have the potential to remedy the problems which had become evident during implementation.

## Additional Concluding Statements

Concluding statements have been made in response to the three questions which guided the study. However, unanticipated findings emerged from the study about which concluding comments must be made. The unanticipated findings focussed on three areas: a) preparation of nurses for teaching and for program development and implementation; b) education of patients with a chronic illness, and; c) characteristics of the program.

### Preparation of Nurses for Teaching

Nurses who volunteered to teach the program were educated in two different levels of nursing programs. Two of the nurses had a nursing diploma plus a Post-R.N. baccalaureate degree. The remaining two nurses had a nursing diploma. Based on the extensive nursing literature which assumes that patient teaching is an integral part of nursing care (Bille, 1981; Jenny, 1978, 1979), it would seem reasonable to assume that all four nurses would have a solid body of knowledge about the process of teaching, the methods of teaching, the components of a teaching program, and some knowledge about curriculum development and evaluation.

However, the evidence in this study was disturbing and illustrated clearly that the nurses did not understand, through no fault of their own, even the basic tenets of teaching or of mounting a program. They did not know how to identify what content to include in the program, how to order the content, how to collect information about patient needs, or how to design and deliver a class. They did not know how to solicit information from patients. For example there was no evidence in the data that the nurses knew how to ask paraphrasing, probing or reflective questions or how to design a simple questionnaire, the basic tools for soliciting feedback. The data indicated that the nurses never did identify what were the expected learner outcomes, and that the nurses had difficulty developing the philosophy and goals of the program. The nurses did not know how to prepare agendas, run a meeting, brainstorm, design time-lines, take minutes, prepare bibliographies, establish short and long term goals and how to collaborate in a group setting. The nurses had volunteered to participate in a task for which they literally had no preparation.

It cannot be concluded that one type of educational preparation was better than the other, for while the nurses who had the baccalaureate degree seemed to have less difficulty developing the program philosophy and goals, it was the nurse with the diploma preparation who appeared to have best identified the components of a traditional teaching module. Ruth based her ability to develop the components on her previous teaching experience and intuition, not her educational preparation.

It must be emphasized that the above statement are not meant as a criticism of the nurses, for the evidence indicated that the nurses did the very best they could given the circumstances and that they frequently asked for assistance. The statements made are a criticism of the education systems from which the nurses graduated, of the systems of in-service education within hospitals where staff nurses work, and of the kinds of supervision and role-modelling which staff nurses receive in the work setting.

## Education of Patients With a Chronic Illness

A second unanticipated finding was that these patients, some who had the chronic illness for over 20 years, had received little structured education about their disease prior to becoming involved in the program. It became evident that some of the patients were avid readers and collectors of material related to their disease, and that some of the patients had developed creative methods to become their own advocate and to maintain control of their preferred life style. These activities on the part of selected patients, however, were entirely self-initiated and self-directed. They had received little direction or support from a health-related source. Other patients appeared to know nothing about the disease, about how to link with support groups, or how to work with or in spite of their family doctor to seek care from a specialist.

This finding is disturbing. It suggests that doctors do not do an adequate job of educating patients, that established agencies do not provide educational opportunities to the large numbers of patients requiring these services, and that health care professionals, particularly nurses either do not act or are ineffective as patient advocates.

Perhaps the finding suggests, as the patients had suggested, that health care professionals see a chronic illness as part of life, part of the aging process and as one group of diseases and symptoms about which little can be done and which the patient 'must learn to live with.' The reports of the health care professionals in this study disputed that finding. However, at times their actions, particularly those of the doctors, did not. Again, it must be reiterated that based on the evidence in the study, the doctors and the nurses did not solicit information about what the patients wanted and needed. The doctors and nurses wanted the patients to comply with prescribed regimens. The patients wanted to be supported to live the kind of lifestyle which they chose, not one which complied with the vision of the health professional.

## Characteristics of the Program

The third unanticipated finding of the study was that while the implementers recognized the multidisciplinary components of the teaching program, they did not think of implementation as an interdisciplinary endeavour. Some of the nurses talked of taking over the program and of teaching anything they wanted to teach to whomever they wanted to teach. The physiotherapist talked about establishing a multidiscipline committee on the one hand and about maintaining control of criteria of patient selection on the other. The doctors talked about maintaining control of patient care but allowing any other discipline to coordinate and teach in the program as long as that discipline functioned within clearly defined parameters. Both the doctors and the physiotherapists thought that nursing had a role in the program; the physiotherapist reporting that "even nurses could teach parts of the program" and the doctors reporting that "even a nurse could coordinate the program". It seemed as if each discipline while giving lip service to the concept of a multidiscipline program, were in reality more concerned with maintaining the status of their profession, maintaining control over other disciplines, and establishing boundaries within which other disciplines should function.

The only participants in this change process who viewed implementation of the program as a multidisciplinary endeavour were the patients. The patients clearly saw the five interconnected aspects of the program to be the physiotherapy component, the nursing component, the pharmacy component, the social services component, and the medical component. This is not surprising, for it was only the patients who ever experienced the total program. To the other participants, the program centered on their own particular area of expertise.

## Recommendations

Based on the findings and conclusions of the present study, five sets of recommendations are presented.

Recommendations for Persons About to Become Involved in a Unit-Initiated Change Process

1. That a leader at the unit level with a firm foundation of teaching knowledge and demonstrated management ability be identified during the adoption stage. If no leader is available, delay initiation of the project.
   1.2 That staff with knowledge, skill and experience required to implement the change be identified during the adoption stage.
2. That during the planning for development transition stage, the selected implementers along with the leader engage in regular, extended periods of discourse (e.g., every day, all day, for a number of weeks) to:
   2.1 review what occurred during the adoption stage;
   2.2 clarify the philosophy and goals of the organization;
   2.3 identify the initial concerns of the implementers;
   2.4 learn how to participate in the change process (e.g., set long and short term goals, develop agendas, establish priorities, take minutes of meetings, brainstorm);
   2.5 clarify what the implementers believe constitutes the domain of the disciplines involved in the change process (e.g., nursing and teaching);
   2.6 identify the philosophy and goals of the change process;
   2.7 assess the amount of congruence between the goals of the organization and the goals of the program;
   2.8 clarify the role of each participant who will become

involved in the change both within and without the unit;

2.9 identify antecedent conditions which may influence implementation;

2.10 identify other departments and personnel which should be involved in or consulted with during the development and implementation stages;

2.11 analyze the work technology of the unit;

2.12 identify required and available resources for development and implementation in terms of money, time, services, and expert consultants. Assess the sufficiency, consistency and quality of available resources. Identify alternate or contingency resources;

2.13 identify staff development activities to be conducted during the development and implementation stages.

3. That during the development stage the implementers:

3.1 be made aware of available materials and models of existing similar programs;

3.2 develop required materials (e.g., lecture content, lesson plans, teaching modules, teaching aides);

3.3 design information systems (e.g., documentation about the program, record keeping systems, patient assessment forms);

3.4 design preliminary strategies for learner follow-up and program evaluation;

3.5 design a strategy for pilot implementation;

3.6 clarify the goals and means of implementation;

3.7 develop strategies to ensure that regular discourse occurs among the implementers as a group and that regular staff development activities and regular planning and assessment activities are conducted throughout the remainder of the change process.

4. That during the implementation stage:
   - 4.1 informal activities be budgeted for in terms of both time and money to allow the implementers to engage in reflective conversation about the meaning of the change process and to allow resocialization to occur;
   - 4.2 senior administration consistently and visibly demonstrate their support of the change process;
   - 4.3 leaders at the unit and area supervision levels be kept and keep themselves informed of implementation activities;
   - 4.4 expert consultants be available;
   - 4.5 staff who are not directly involved in implementation activities be kept informed of the progress of the change process;
   - 4.6 strategies be designed to integrate the goals of the change process with the goals of the unit; and the work technology of the program with the work technology of the unit.

## Recommendations for the Preparation of Nurses

1. That further study should be conducted to determine if increased content and experience relating to a) the adult learner, b) theories and process of learning, and c) methods of

teaching should be added to the diploma and the baccalaureate programs for educating nurses.

2. That nursing educators and theorists collaborate with nursing administrators and nursing clinicians to define the domain of nursing, to develop theories of nursing, and to operationalize the developed concepts in the day to day activities of nurses as they care for patients in health care settings.
3. That nurses who are interested in pursuing a career pattern with a program planning focus be prepared at the Master's level and that in addition to nursing courses, they take an extensive number of courses in the Faculty of Education on curriculum development and program evaluation, theories of learning, methods of teaching, educational administration and project administration, change theory, policy analysis and program planning.
4. That studies be conducted to identify the characteristics needed by effective change facilitators.

## Recommendations for Health Care Institutions/Agencies

1. That the work technology of a nursing unit includes patient teaching as a priority component.
2. That departments of inservice, education, and/or research in health care institutions employ a nurse who is prepared at the master's or doctorate level and who has demonstrated ability to consult in the development and implementation of patient teaching programs.

3. That unit leaders and area supervisors, employed in health care institutions, have a firm foundation of knowledge and demonstrated ability in the domains of teaching, program planning, and change in addition to the domains of nursing and leadership.

Recommendations for Care of Patients With a Chronic Illness

1. That patients who are diagnosed as having a chronic illness be monitored on a regular basis by a specialist.
2. That patients with a chronic illness take part in an educational program soon after diagnosis and take part in refresher/update programs at regular intervals.
3. That doctors treating patients with a chronic illness promote existing patient education programs, facilitate the establishment of new patient education programs, reassess and improve their own patient teaching abilities and techniques, and tailor treatment regimens to meet the needs of the individual patient.
4. That patients with a chronic illness be informed of teaching programs and support groups which are available and be assisted to link into such resource systems.
5. That all health care personnel take a role in patient advocacy; in assisting patients with a chronic illness to walk through rather than stumble into obstacles inherent in the health care bureaucracy.

### Recommendations for Further Study

1. That further studies using an inductive, emic approach be conducted about the process of change on nursing units, about patient teaching programs, and about the education of patients with a chronic illness to corroborate or refute the findings of the present study.
2. That studies be conducted in health care settings to examine the similarities or differences between the response to and needs of patients of different age groups who have a chronic illness.
3. That studies be conducted in health care settings to examine the similarities and differences between the response of females and males to chronic disease. Although not a major point of discussion in the present study, the one male patient appeared to respond to the disease differently and to have different needs in terms of education and treatment than did the females.

## Reflections About the Inquiry

The case study approach using qualitative methods for data collection and data analysis was both feasible and useful to examine the process of change. Strengths and weaknesses of the approach are discussed.

### Role of the Investigator

The investigator was aware that she was an outsider to the unit and that she was the primary instrument of data collection and analysis in the study (Glaser and Strauss:1967, 1978; Schatzman and Strauss:1973, Pelto and Pelto:1978, Spradley:1979, Agar:1980, Guba and Lincoln:1981, Bodgan and Biklen:1982). Consequently, she was initially concerned that her presence would either inhibit the informants or would cause them to tailor their response to what they thought the investigator wanted to hear.

During the feasibility assessment, the nurses indicated that they would probably talk to and confide in the investigator. This observation was corroborated throughout the study as has been demonstrated in the interview and field notes excerpts.

The informants on the whole were accepting and trusting of the investigator. As one of the nurses said on February 1, 1984 after the tape recorder had been turned off, "I know that when I tell you this, it won't go any further." One nurse liked the interview situation as it was a time when she could sit down and have a "little chin-wag." It seemed that the nurses, in particular, were telling the investigator about problems which they had already brought to the attention of the appropriate person without resolution or about problems they would discuss with the appropriate person if only they could talk to that person or if only that person would listen and take action.

The investigator seemed to be a 'sounding board'. Informants would 'think out loud' in response to probes. Numerous excerpts are contained in Chapters 4 to 8 which illustrate how the informants thought of alternative strategies and possible solutions to problems which they had not thought of until they were involved in the interview situation. The informants would make comments like, "I hadn't thought of that until this interview."

The informants, particularly the nurses, seemed to think of the investigator as a colleague and a nurse. Frequently throughout the interviews, the nurses would make comments like, "You know how it is on the unit. You've worked on units before" or "You remember how long the half-life of [a specific drug] is" or "You know how nurses behave."

It became evident from the informants' comments that they also considered the investigator to be a resource person and were somewhat curious about her own career history. They frequently asked for her thoughts on how to design forms, ways to collect data, how to solve a particular problem, and how to become knowledgeable and skilled in the areas of program development and teaching.

As demonstrated in the excerpts, the investigator encouraged the informants to discuss the effects on themselves and their work of taking part in the interviews. They commented that the investigator was "the only person who listens to us," "the only person I can talk to," or "the only person who's asked me about the program." The interview situation seemed to be the one time when the nurses could "sit and make plans or think about the program."

It is the opinion of the investigator that the non-judgemental, neutral, accepting role which she assumed during the study, the guarantee of anonymity, and the considerable length of the study period accounted in large part for the willingness of the informants to openly and candidly discuss their experiences.

## Sampling Plan

A variety of sampling plans were used throughout the study. While the 'key informants' provided the bulk of the data, the snowball sampling plan used later in the study was effective. Informants interviewed as a result of the snowball sampling plan verified emerging themes, added new dimensions and perspective to data collected, and occasionally identified new factors which had influenced the process of change.

Had the study continued for an even longer period of time and had the investigator the energy to conduct more interviews per week, many other groups of informants could have been interviewed. The pharmacist, the occupational therapist, the social worker, the head nurse in the out-patients clinic, the President of the volunteer Association and more patients, including those from the rural areas, were possible interview candidates. However, as the data continued to be collected from the different selected informants, saturation of the categories began to occur rather quickly. The investigator felt comfortable that a realistic picture of the experience had been captured when the data collection period ended in September of 1984.

## Ethical Considerations

There were two major interrelated ethical considerations. First, information in the interview data had to be used discreetly. Second, the anonymity of the hospital, the unit, and the informants had to be maintained. Because the informants were so candid, the investigator occasionally made the decision not to include certain excerpts which were personally revealing and/or were defaming to the informant or others. Excerpts of this nature which were included contained information which seemed to be 'common knowledge,' that is the informant and those referred to in the excerpt were well aware of the feelings and opinions expressed. The informants occasionally stated that they did not care if the whole world knew what they were saying.

Maintaining anonymity and confidentiality of the setting and those in the setting proved to be an intriguing exercise. Other nurses whom the investigator would meet while on route to unit Y, would ask what the investigator was doing in the setting. Colleagues, committee members, funding agencies and other interested persons would ask questions about the location of the study and the type of disease the patients had. Two particular incidents illustrate the problems encountered. Field notes, May, 1983:

> I: I have applied to a nursing funding group for monies to conduct the study. Today I received a phone call from the secretary (I think she's a nurse) of the group.
>
> Secretary: We've reviewed your proposal but you didn't fill in the name of the hospital or identify the kinds of patients being studied.
>
> I: I marked those areas as confidential.
>
> Secretary: The committee won't review the proposal until that information is given. We have to know that you have been given approval by the hospital.
>
> I: I included letters of approval in the appendix.
>
> Secretary: The letterheads and signatures have been blanked out.
>
> I: I included a letter from the dissertation chairman stating that I have approval from the hospital.

> Secretary: The committee doesn't think that's good enough.
>
> I: I cannot give you the information as I've guaranteed anonymity and confidentiality.
>
> Secretary: Well there's only 17 to 23 members on the committee and they're not going to tell anyone.
>
> I: I'll take a chance on not getting the funds.

In July of 1985, the following field notes about another incident were recorded:

> Today I met a professor who knew I was doing a doctoral dissertation. We talked about the study.
>
> Professor: Where are you doing the study?
>
> I: The location is confidential, I have guaranteed the informants anonymity.
>
> Professor: Oh, I was just wondering because I have a student who is a nurse and is doing a study at the [blank] hospital. I wondered if it was the same hospital.
>
> I: [No comment].
>
> Professor: I'm asking you if that's where you're doing your study.
>
> I: I'm telling you the setting is confidential.
>
> Professor: There's a difference between anonymity and confidentiality.
>
> Exit professor.

Throughout the study, the investigator encountered many situations similar to those described above. Such situations often occurred 'on the spur of the moment' requiring the investigator to make 'on the spot' decisions. Decisions made were discussed with the dissertation chairman 'after the fact', on most occasions, and 'before the fact' when possible.

## Data Collection

The process of data collection evolved as the study progressed. The original intention of the investigator was to take notes during group interviews. Three pilot group interviews were conducted. Hand notes were taken during the first group interview, but the investigator could not 'keep up' with the informants. The second group interview was tape recorded and the secretary quit after attempting to transcribe the first four pages. A second secretary transcribed the second and third group interviews and threatened to resign if something was not done to make the voices more distinct and to prevent the informants from all talking at once. Single interviews were conducted throughout the remainder of the study.

Minor taping problems occurred. The investigator had to take notes during one home interview because the 3-way plug on the tape recorder would not fit into the 2-way electrical outlets in the informant's home. An adaptor was carried during the remaining interviews.

Interview sessions conducted in the unit office were often interrupted by phone calls, and by other nurses coming to get the informant to do or complete a procedure. In addition, noise was occasionally a problem. The office backed on to the housekeeping room. When the water taps and vacuum system in the housekeeping room were turned on, muffled background noise occurred in the office. Informant comments which occurred at this time had to be summarized and paraphrased by the investigator to ensure that they had been captured on tape.

The unstructured responsive interview approach was appropriate for use in the study. Having identified some possible interview probes and having had a moderate amount of interviewing experience prior to conducting the interviews proved to be valuable assets for the investigator during the interview period. The probes allowed the interviewer to establish loose boundaries on how much dross and spiel to allow during an interview and to recognize both when they did occur. The probes also allowed the investigator to delve much deeper beyond the surface data than would have otherwise been possible.

Prior experience with interviewing allowed the investigator to be flexible, and to use alternate techniques as the situation dictated. Because of previous experience, the investigator was also able to pace the interview and to keep probes on the 'back burner' until it was appropriate to bring them forward.

The decision not to take notes during the interview was appropriate, for the period was all consuming, intense and fatiguing, requiring total concentration on the part of the investigator. Eye contact between the investigator and the informant was almost constant as the informant had the investigator's undivided attention. The interview period seemed to be a time for the informants to chat, to provide information, and to 'get concerns off their chest.' Note taking during this period would have perhaps been disruptive, reminding the informant of the research nature of the study and breaking the concentration of the investigator.

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## Data Analysis

Data analysis and data collection, at times, occurred simultaneously. The most vivid example of this occurred during the eighth interview. While the informant was discussing the 'old program,' the theme or category heading 'antecedent condition' literally seemed to flash in front of the investigator. It was after this experience that the investigator became aware of the need to become sensitive to the almost unconscious coding of data that was occurring and to design some method or system or capturing the code on tape. The resulting system was that the words of the informant would be repeated with a code word inserted. For example, the informant phrase "old program" was repeated by the investigator during paraphrasing as "existence of the previous program." The word 'previous' was the code word relating to the theme or category of 'antecedent condition.' This technique was used cautiously and only when there appeared to be a 'tight fit' between the data and the emerging category.

During the data collection period, as data were analyzed, the investigator would discuss and attempt to validate the emerging categories with others, particularly the dissertation chairman. The following procedure was used. The person was requested to read a page or series of pages of transcript and to label the predominant concept. The category which caused the most labelling difficulty was the one eventually labelled 'multiple realities.' This category at various times was labelled as 'personality conflicts,' 'roles, needs and expectations,' 'reward systems,' 'group think,' 'burn out,' 'locii of power,' and 'meaning of change.'

Two informants validated the data presentation. The investigator also used the disseration committee to help validate the data presentation and encouraged them to point out where the investigator had been led astray. On the whole, the members agreed with the presentation of the categories, putting check marks, asteriks, and a variety of supportive comments in the margin. When they did not agree with the category label or felt that a particular point had not been clarified or emphasized, they made comments like, "This is important, be sure to make special mention of this point." "You've missed the importance of this point." "You've going to have to discuss this, it's so obvious." "This is a jargon term, say what you mean."

Also of interest was the observation that the committee members began to 'talk to the data' which had been presented. The following excerpts from the margins illustrate this point. "Why did she do that?" "Why didn't she take a leadership role?" "Wow?" "What was wrong with [the informant]?" "Maybe this was the main problem." "What was [another informant] doing all this time?"

The investigator also validated facts about specific events with the director of nursing services. Such a request for validation was prefaced with an explanation that facts were being requested and that interpretations would be considered in the context of all the findings.

In retrospect, the study took longer to complete and was more complex than the investigator had anticipated. A team approach would have been valuable and appropriate to examine the process of change in the present study.

## Epilogue

On August 28 of 1985, 11 months after data collection had ended, one final telephone interview was conducted with the second head nurse on unit Y to obtain a report on the status of the teaching program.

As of August 1985, the teaching program is still taught once per month on unit Y. The second head nurse has returned from her leave of absence. Only one of the original five key informants now work on unit Y. The first head nurse, Beth, Ruth, and Ann have left. Five nurses teach the classes. Three staff nurses, all recent graduates and two who have a B.Sc.N., have joined the teaching team. One of the staff nurses who joined the team in April of 1984 still teaches in the program. The other staff nurse who joined the team in April, 1984 and became the assistant program coordinator has left unit Y to work on another unit in the hospital. Marg still teaches in the program.

Three classes, the introduction and film, stress and quackery are still taught by the nurses in the evenings. A representative of the social services department gives one class during the daytime. One pharmacist and a teaching nurse give a combined class on medications during the daytime. Because the medication lecture is given during the day rather than the evening shift, a number of the staff nurses have sat in on the lecture. An orientation program about the teaching program was started for the staff nurses. They were encouraged to attend each of the evening classes. However, the staff nurses were reluctant to come in on their own time. A progress report about the program is given by the second head nurse and/or a member of the teaching team at staff meetings which are held every two months.

Marg now conducts a 'support group' meeting Thursday evenings on the unit. All patients from unit Y, families and out-patients are invited to attend. According to the second head nurse this 'off-shoot' of the program has been a great success.

A new physiotherapist is working with unit Y and the first physiotherapist now has decreased contact with the unit. The second head nurse, the physiotherapist, the occupational therapist, and a representative from the social services department have begun to attend the Wednesday afternoon conference with the doctors. A joint decision is made to admit patients to the teaching program and the teaching program is discussed.

The staff nurses on unit Y are still scheduled for work according to two rotation patterns. However, each staff nurse is now a member of one of two teams, a management team or the teaching team. The rotation patterns were designed to be congruent with the team functions. Therefore, the teaching team is now on one rotation, making it easier for the teaching nurses to communicate with each other. At least two members of the teaching team will work together at some time during a given week. The second head nurse meets with the teaching nurses every two months to discuss the program. The area supervisor is not involved in the program.

Three of the staff nurses, including two of the teaching nurses, and the second head nurse attended a week long course on nursing patients with the chronic illness during April of 1985. The teaching nurses are now implementing some ideas which they learned from the course and are developing teaching aids.

The volunteer Association no longer funds the program. Members, who also have the disease, were tired and could not take part in fund raising activities. As a result, the Association felt unable to stretch their limited financial resources to continue funding the program. The teaching nurses are paid from the unit Y budget. According to the second head nurse, implementation of the program is now a success.

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# APPENDIX A

## PROBES GENERATED BY PROVUS PITTSBURGH EVALUATION MODEL
(Tables 1, 2, 3 and 4)

# APPENDIX A

## PROBES GENERATED BY PROVUS PITTSBURGH EVALUATION MODEL

Table 1

Probes Related to the Defined and Planned Program

1. How were the intended outcomes identified?
2. What criteria were used to determine which staff would teach the program?
3. What were the characteristics of the teaching staff?
4. How did the teaching staff feel about their new role?
5. What criteria were used for patient selection to the program?
6. What was the response of the total unit as the planning proceeded?
7. What was the nature of decision-making and conflict resolution?
8. What resources were identified as required to implement the program?
9. Were sufficient resources provided?
10. What was the nature of administration's (area supervisor, nursing unit supervisor) response to the planning phase?
11. Was outcome assessment considered?

## APPENDIX A (Continued)

### Table 2

### Probes Related to the Installation/Implementation of the Program

1. What kinds of problems arose?
2. How did the organization respond to problems?
3. How were required changes identified?
4. How were changes made?
5. What changes were made?
6. What was the nature of the participants' (patients, families, unit staff, teaching staff, administration) response to implementation?
7. What program outcomes emerged during the implementation phase?
8. Were these outcomes congruent with the intended outcomes?
9. Were the identified resources adequate for implementation?
10. What additional antecedent conditions emerged as important?

APPENDIX A (Continued)

### Table 3

### Probes Related to Process (Continuation)

1. What was the level of motivation of participants like?
2. What happened to the larger organization?
3. How does the implemented program run?
4. Did the process move through stages and how?
5. What factors were conductive or detrimental to maintaining the program?
6. How were plans made for continuation?

### Table 4

### Probes Related to Product (Outcomes)

1. How were outcomes of the program identified?
2. Were the strengths and weaknesses of the program identified?
3. What was the nature of the responses of participants (patients, families, unit staff, teaching staff, administration) to the program?
4. How was the question of program continuation resolved?
5. What were the side effects of developing and implementing the program?
6. How did the organization respond to these side effects?
7. How does the organization plan to respond to these side effects in the future?
8. What was learned that could be useful to other units and/or organizations?

# APPENDIX B

# INFORMED CONSENT FORM

# APPENDIX B

## Informed Consent Form

| | |
|---|---|
| Project Title: | The tentative title of the project is "Examination of A Nursing Unit in Transition." |
| INVESTIGATOR: | Darlene Elliott, Reg. N., B.Sc.N., M.Ed., Doctoral Student<br>Department of Educational Administration, U. of A. |
| ADVISOR: | Dr. D.A. MacKay, PROFESSOR, Department of Educational Administration, U. of A. |

This is to certify that I, ______________________________ hereby agree to
(print)
participate as a volunteer in a research project which examines the process and possible results of establishing a patient teaching program on a nursing unit.

I consent to be interviewed, for a tape-recording to be made of that interview and that comments I make may be reported verbatum.

I understand that I am free to deny any answer to specific questions during the interview.

I consent to be observed during the duration of the study and for records to be kept and reported of the observations.

I understand that my name will not be disclosed at any time.

I further understand that I may withdraw from the study, or refuse to answer any questions without penalty. I am free to ask questions about the research, and they have been answered to my satisfaction.

______________________________
(SIGNATURE OF PARTICIPANT)

______________________________
(DATE)

______________________________
(SIGNATURE OF WITNESS)

______________________________
(SIGNATURE OF INVESTIGATOR)

# APPENDIX C

## LETTER OF SUPPORT FROM DOCTOR ON UNIT Y

# APPENDIX C

# LETTER OF SUPPORT FROM DOCTOR ON UNIT Y

(delete) [illegible]
(delete)
(delete) [illegible]
[illegible]
(delete) [illegible]
[illegible] (delete)

(delete)

May 9, 1983

To whom it may concern:

Re: Darlene Elliott's Study
Proposal

I have read and support the proposal developed by Mrs. Darlene Elliott to examine the process involved in planning and implementing the patient teaching program, and to establish the worth of the program. I agree with the documentation in the proposal that this type of evaluation activity is needed and is often neglected.

The proposal contains a concise description of the purpose, significance and research based reasons for conducting the study. In addition, the analytical framework, research design and data collection and analyses techniques appear to be most appropriate for the type of study proposed. The activities as described present no threat to patient well being.

It seems to me that the activities proposed by Mrs. Elliott represent a unique opportunity to gain valuable insight into how a hospital unit actually goes about implementing a patient teaching program and may result in some valuable suggestions for future similar projects.

It is my understanding that Mrs. Elliott is available to meet with me and/or others to discuss the study.

I recommend that Mrs. Elliott be given approval to conduct the study. Should it be necessary, I would be pleased to provide further elaboration.

Yours sincerely,

(delete) , M.D.

S /plc

# APPENDIX D

# CHARACTERISTICS AND EXPERIENCE OF THE INVESTIGATOR

# CHARACTERISTICS AND EXPERIENCE OF THE INVESTIGATOR

## Personal Data

Name: Darlene Jean Vigeant Elliott

Place of Birth: Saskatoon, Saskatchewan

Age: Early forties

Personal Status: Married, two children

## Educational Background

Registered Nurse Diploma. Saskatoon, Saskatchewan: St. Paul's Hospital School of Nursing, 1966.

B.Sc.N. (Major in Teaching and Administration). Kingston, Ontario: Queen's University, 1969.

M.Ed. (Educational Administration). Edmonton, Alberta: University of Alberta, 1982.

Ph.D. (Educational Administration). Edmonton, Alberta: University of Alberta. Will complete program in 1985.

## Experience

Co-investigator. Conducted a study with Dr. D.A. MacKay to examine the learning environment in a diploma School of Nursing. January-April, 1985.

Research Nurse (part-time regular). Evaluation consultant for a joint project being conducted between a hospital in Eastern Canada and a hospital in Western Canada to develop and implement a clinical ladder and corresponding reward system for staff nurses. 1984-present.

Co-investigator. Conducted a study with Dr. D. A. MacKay to determine the feasibility of articulating a Nursing Assistant Program with a college Diploma Nursing Program in Western Canada. 1984.

Research Assistant. Participated in a study with Dr. D. A. MacKay to analyze the dissolution of a board of Teacher Education and Certification, 1983-1984.

Co-investigator. Conducted a follow-up evaluation, with Dr. P. A. Field, of the graduates of a University Baccalaureate Nursing Program, 1982-1983.

Co-Investigator. Conducted a study with Dr. D. A. MacKay to examine the satisfaction of staff nurses on a nursing unit in an acute care hospital, 1982-1983.

Principal Investigator. Conducted a comparative follow-up evaluation of the graduates of a University Post-RN Baccalaureate Nursing Program for M.Ed. thesis, 1981-1982.

Research Assistant. Participated in a study with Dr. A. Konrad to identify the professional development needs of further education coordinators in Alberta, 1981-1982.

Executive Assistant to the Steering Committee. Directed the final implementation and evaluation stages of the project to "Develop an Innovative Learning System for the Preparation of Nursing Assistants in Alberta." Alberta Vocational Centres, Edmonton and Calgary, 1980.

Content Developer. Participated in developing, implementing and revising the innovative learning system described above. 1979-1980.

Nursing Instructor. Instructed (both in the classroom and in the clinical area) third year baccalaureate, first year hospital diploma, first year of a two + one year hospital diploma, refresher nursing, nursing assistant, and nursing orderly students. The areas of instruction included: general surgery, I.C.U., general medicine, fundamentals of nursing, anatomy and physiology, respiratory needs of patients, extended care and care of patients in nursing homes, 1969-1979.

General Duty Nurse. Was a general duty nurse on neurosurgey, burns, G.I., general medical and general surgical units, 1966-1977.

Workshop Facilitator. Developed and conducted workshops on communications, death and dying, and program evaluation.

Committee Chairman. Chaired faculty committees on continuing education and curriculum development and professional association information committees.